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Perceptions of Care During the Prenatal Period: An Ethnonursing Study of African American Childbearing Women in the Military Health System

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PERCEPTIONS OF CARE DURING THE PRENATAL PERIOD: AN ETHNONURSING STUDY OF AFRICAN AMERICAN CHILDBEARING WOMEN IN THE MILITARY HEALTH SYSTEM

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Approved March 15, 2017

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ABSTRACT

PERCEPTIONS OF CARE DURING THE PRENATAL PERIOD:
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Dissertation supervised by Dr. Richard Zoucha

Introduction: The military health system (MHS) offers prenatal care at no-cost, but African-American women eligible for prenatal care still have low/no/late utilization. No studies have sought to understand factors that influence African American women's use of early and continuous prenatal care or their perceptions of the care they received in the military health care system. The purpose of this research was to understand how African American women in the MHS perceived their care during the prenatal period. **Methodology:** An ethnonursing study was conducted in two military treatment facilities. The sample comprised 21 informants. **Findings:** Leininger's Four Phases of Ethnonursing Data Analysis revealed three themes: (a) African American military women in the MHS have positive prenatal care (PNC) experiences when psychosocial and informational support is given by trusted and familiar sources, (b) Health care, financial,

prenatal, and educational resources are valued components for taking care of self and preparing for baby, and (c) Emotional and instrumental support from expectant fathers, family, friends, and the military reinforced PNC beliefs, decreased maternal stress, and promoted expectant fathers' participation in PNC. **Discussion:** Women experienced positive prenatal care experiences when they had continuity of care and a circle of support. Recommendations for care that is culturally congruent and future studies are offered.

Key words: African Americans, women, military, ethnonursing, prenatal care, focus groups

DEDICATION

This dissertation is dedicated in memory to my mother who encouraged me to always have faith in God, to believe that all things are possible, and to go further and reach higher than she ever could. Although she is no physically with me, I know she is smiling down on me and her spirit lives on in all of my endeavors. She is the angel who watches over me.

To my amazing husband, Darrell, thank you for your love, patience, and never-ending support. Your sage advice and powerful words motivated me and kept me grounded. I thank God for you! To my daughter's, Ashley and Kelsey, you are the reason I strive so hard to achieve what may seem impossible. I pray that my journey has inspired you to reach higher, go further, and never give up. Know that no matter what trials and tribulations you encounter, if you go with God, you will get to where you are supposed to be. Just have faith and believe.

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Introduction

1.1 Introduction

Prenatal care (PNC) visits are important for the health of the mother and infant (Child Trends Databank, 2015). Early and regular PNC has been associated with healthy pregnancy weight gain, increased length of pregnancy, decreased adverse risk factors, and increased infant birth weight. Prenatal care also provides the opportunity for women to receive lifestyle and health behavior recommendations, medical management of health complications, and referral to additional resources if needed (P. Johnson, Call, & Blewett, 2010). In 2007, Washington State reported that 79 percent of all pregnant women received prenatal care in the first trimester; however, only 73 percent of African American women receive care in the first trimester compared to 82 percent of White women (W. S. D. o. Health, 2008). Reports from the 27 states, including Washington, currently using the latest revision of the U.S. Standard Certificates of Live Births, revealed that 59.1 percent of African American women received prenatal care in the first trimester compared to 71 percent of all women in the United States and 76.1 percent of White women (National Center for Health, 2012). Despite the known benefits of prenatal care, in 2014, the national rate of late (beginning in the third trimester of pregnancy) or no prenatal care among non-Hispanic African American women was 10 percent compared to 4.3 percent of non-Hispanic White women and 6 percent of all women (Child Trends Databank, 2015). Healthy People 2020 retained the Healthy People 2010 objective to increase the proportion of pregnant women who receive prenatal care in the first trimester to 77.9 percent and those who receive early and adequate prenatal care to 77.6 percent health (Services, 2009).

Pregnant African American women have several risk factors associated with increased maternal, fetal, and infant morbidity and mortality, including increased rates of no/low/late prenatal care visits, hypertensive disorders of pregnancy, tobacco use, and illicit drug use (Quality, 2012; U.S. Department of Health and Human Services, 2011b). In 2007, there were 548 maternal deaths (12.7 per 100,000 live births) related to or aggravated by pregnancy and occurring during or within 42 days postpartum (U.S. Department of Health and Human Services, 2011b); 28.4 percent of these deaths occurred among African American women (U.S. Department of Health and Human Services, 2011a). African American women are 2.7 times more likely than White women to suffer maternal death (U.S. Department of Health and Human Services, 2011a, 2011b).

When hypertension occurs in pregnancy, there is an increased risk of fetal intrauterine growth restriction (IUGR), preterm delivery, neonatal asphyxia, neonatal hypoglycemia, and maternal seizures. Among African American women, the rates of chronic hypertension and pregnancy-associated hypertension (gestational, pre-eclampsia, or eclampsia) were 22.8 percent and 49.2 percent respectively, compared to 11.1 percent and 38.7 percent for all women (U.S. Department of Health and Human Services, 2011b). In a report by the National Survey on Drug Use and Health, pregnant African American women were twice as likely to have used any illicit drugs in the past month compared to pregnant women of all other races (Quality, 2012).

The national infant mortality rate (infant deaths per 1,000 live births) among African Americans was significantly higher than the rate for infants of all races, 11.61 percent compared to 6.14 percent, respectively (Murphy, Xu, & Kochanek, 2012). In Washington, the infant mortality rate for African Americans decreased from 9.1 percent in 2007 to 5.6 percent in 2009, but rose slightly to 5.9 in 2010 (W. S. D. o. Health, 2012). Although this meets the HP 2020

objective to decrease infant mortality to 6.0 percent or less, this rate is still higher than the rate for white infants which has been holding steady at under 5.0 percent since 2007 department (W. S. D. o. Health, 2012; Services, 2009). The leading causes of death among African American infants, in order, are low birth weight, congenital malformations, sudden infant death syndrome (SIDS), and maternal complications. African Americans have the highest mortality rates from low birth weight, and are three times as likely to die as infants due to complications related to low birth weight as compared to White infants (Mathews & MacDorman, 2011). Compared to White women, African Americans are three times as likely to have an infant death related to preterm birth (Mathews & MacDorman, 2011). In Washington, approximately 330 infants are born each year to African American mothers who smoke (W. S. D. o. Health, 2009). Smoking during pregnancy is of particular concern because it is closely linked to excess fetal and infant mortality, including low birth weight and SIDS. African American babies have a two times greater risk of dying from SIDS as White babies (Mathews & MacDorman, 2011).

1.2 Domain of inquiry

The domain of inquiry for this research is the perceived experiences of care of African American military women and female spouses during the prenatal period, the influence of worldviews and cultural/societal factors, and the impact of nursing practices.

1.3 Purpose and Goal

The purpose of this ethnonursing study was to understand how African American childbearing women within the Military Health System (MHS) perceived their care during the prenatal period, how their worldview and cultural and societal factors influence care, and the impact of professional nursing practice on cultural care during the prenatal period. The specific aims of this research are to (a) understand experiences of care during the prenatal period; (b)

understand the care practices which are most congruent with healthy lifeways during the prenatal period; (c) understand how worldview and cultural and societal factors influence care; (d) discover and describe cultural care knowledge that promotes health and well-being during the prenatal care period; and (e) explore ways to integrate prenatal care that is culturally congruent and meaningful for African American military women and female spouses.

1.4 Rationale

Prenatal care services are offered at no cost to all active duty military women and family members under Tricare Prime, a managed care option providing comprehensive health coverage. Additionally, a wide array of resources including social workers/case managers, parenting and financial preparation classes, new parent support, and home visitations are also available at no cost. Despite having free healthcare coverage and resources, African American women in the MHS continue to have low/no/late PNC utilization. In a 2005 Department of Defense survey, military African American women were slightly less likely to initiate prenatal care in the first trimester compared to women of other racial and ethnic groups (Bray et al., 2006). Of the active duty military service members, only 14.1 percent are women and of this population, 31 percent are African American women (including Black Hispanics) (O. o. t. D. U. S. o. t. Defense, 2011). Military personnel who are 21-25 years old and without a college degree are less likely to have early initiation of prenatal care (Bray et al., 2006; O. o. t. D. U. S. o. t. Defense, 2011). This is consistent with three military studies on unplanned pregnancy that found that young women who were younger than 24 years of age with lower education were at a higher risk for unplanned pregnancies (Clark, Holt, & Miser, 1998; Robbins, Chao, Frost, & Fonseca, 2005; Thomas, Thomas, & Garland, 2001). Although these studies did not evaluate prenatal care, consideration must be given to age and education as demographic factors that may be related to no/low/late

prenatal care utilization among military women. Of the total active duty military force (n=1,326,273), 43.2 percent are 25 years or younger, 77.0 percent have less than a bachelor's degree, and 55.3 percent are married (Defense, 2014). Family members comprise 57.6 percent of all family members and active duty members (n=3,128,888) (p. 125). More than half of all active duty members are ages 20-25 when they have their first child (p. 138). Research studies evaluating prenatal care utilization among military women are scant and those that include all military women are outdated; however, they do reveal that despite having access to free PNC, the problem of no/late initiation of care also existed among African American women in the MHS. There is a scarcity of research on prenatal care among African American women in the MHS. This study was designed to give them a voice to promote the discovery of knowledge that may fill the gap regarding how culture can impact health care behavior.

1.5 Research questions

The following research questions will guide this study:

1. In the MHS, what are African American women's perceptions of care experienced during the prenatal period?

2. In the MHS, how do worldviews and cultural/societal factors influence African American women's experiences of care during the prenatal period?

3. In the MHS, what ways do nursing practices impact or impede African American women's experiences of cultural care in the MHS during the prenatal period?

1.6 Significance for nursing

Nurses play vital roles in providing education and negotiating plans of care with women. In culturally diverse populations, nurses involved in prenatal care planning may identify cultural concerns related to self-care during the pregnancy, prenatal care, and the growing fetus, but these

concerns may be not be incorporated into the overall care plan. Pregnancy is often the first and only time women receive comprehensive care and individualized prenatal care plans which include full health assessments, lifestyle and health behavior recommendations, medical management of health complications, and if needed, referrals to additional resources (P. Johnson et al., 2010, p. 122). It is a time to promote wellness and preventive care measures through the lifespan; therefore, it is imperative that nurses recognize cultural factors that influence care, and incorporate these into the prenatal care plan. Nurses providing prenatal care to culturally diverse women must understand how culture can impact care during pregnancy in order to develop an appreciation for and an understanding of these women's culturally relevant views of health, illness, and the experiences of care (Zoucha, 1998)

The National Institutes of Health (NIH) (2010) considers cultural competency to be critical to decreasing health disparities and improving access to quality health care that is respectful and responsive to the needs of diverse populations. Culturally congruent nursing care may empower and motivate women to continue seeking care and to become active participants and decision makers in care that promotes health and prevents disease. Care that is not culturally congruent and satisfying may be a deterrent to adequate prenatal care and increase the risk of maternal, fetal, and infant morbidity and mortality. This study was needed because there is limited knowledge about military women and female spouses' values, beliefs, and practices related to pregnancy and prenatal care. No reported studies have explored how African American women perceived their care during the prenatal period. The majority of the participants in this study were not from Washington State, but they were all associated with the military as a service member or spouse and received health care though the MHS. This research and its findings are not meant to disregard each individual's traditions and practices, but to serve

as a model to guide nursing care that is culturally congruent with the values, beliefs, and practices of African American women within the MHS. The findings may also open discourse on prenatal care within the context of these women's lives related to the military and bring forth new knowledge related to care of military African American women and female spouses. This research adds to the growing body of nursing knowledge regarding prenatal care and promotes the importance of applying transcultural nursing concepts during the prenatal period. Nursing care that is culturally congruent promotes optimal health and well being, is useful to those receiving the care, and empowers clients to be active participants in their care planning. Aligning traditional care with transcultural nursing care practices facilitates delivery of care according to professional standards and the cultural needs and expectations of those from culturally diverse backgrounds.

1.7 Orientational definitions

1. Military women and family members: women in this group include active duty service women in the Army, Navy, Marine Corps, Air Force, or Coast Guard, and women married to active duty service members.
2. Prenatal care period: the period of time from conception to onset of labor when prenatal care is given.
3. Human care: related to assisting, supporting, or enabling experiences or behaviors or others with evidence for anticipated needs to ameliorate or improve condition or lifeway.
4. Culture: refers to the learned, shared, and transmitted knowledge of values, beliefs, and lifeways of a particular group that are learned, shared, and usually transmitted intergenerationally over time.

5. Culture care: refers to synthesized and culturally constituted assistive, supportive, and facilitative caring acts toward self or others focused on evident or anticipated needs for the client's health or well-being or to face disabilities, death, or other human conditions.
6. Culture care diversity: refers to cultural variability or differences in care beliefs, meanings, patterns, values, symbols, and lifeways within and between cultures and human beings.
7. Culture care universality: refers to commonalities or similar culturally based care meanings ("truths"), patterns, values, symbols, and lifeways reflecting care as a universal humanity.
8. Worldview: refers to the way an individual or group looks out on and understands the world about them as a value, stance, picture, or perspective about life or the world.
9. Emic: refers to the local, indigenous, or insider's views and values about a phenomenon.
10. Ethnohistory: refers to the sequence of facts, events, or developments over time as known, witnessed, or documented about a designated people of culture.
11. Transcultural nursing: a formal area of humanistic and scientific knowledge and practices focused on holistic culture care (caring) phenomena and competencies to assist individuals or groups to maintain or regain their health (or well being) and to deal with disabilities, dying, or other human conditions in culturally congruent and beneficial ways.
12. Cultural competent nursing care: refers to the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individuals or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death.

    (Leininger & McFarland, 2002, pp. 83-84)

1.8 Assumptions

Assumptions that will guide this study are:

1. Care is the essence and the central dominant, distinct, and unifying focus of nursing.
2. Care (caring) is essential to curing or healing for there can be no curing without caring.
3. Culturally based care is essential for wellbeing, health, growth, and survival and to face handicaps or death.
4. Culturally based care is the most comprehensive and holistic means to know, explain, interpret and predict nursing phenomena and to guide nursing decisions and actions.
5. Every human culture has generic (lay or traditional) care knowledge and practices and usually professional care knowledge and practices to be discovered and used for culturally congruent care practices.
6. Culture-care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion, kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental context of cultures.
7. Culturally congruent and beneficial nursing care can only occur when care values, expressions, or patterns are explicitly known and used appropriately, sensitively, and meaningfully with people of diverse or similar cultures.
8. The ethnonursing qualitative research method provides an important means to accurately discover and interpret *emic* and *etic* embedded, complex, and diverse culture-care data.
9. Transcultural nursing is a discipline with a body of knowledge and practices to attain and maintain the goal of culturally congruent care for health and wellbeing.

   (Leininger, 2006, pp. 18-19)

1.9 Summary

Prenatal care is considered vital to the health and wellbeing of women and their developing fetuses; however, despite having no financial barriers to health insurance coverage, African American women within in the MHS have high rates of low/no/late prenatal utilization. There was a gap in knowledge to inform our understanding and response to this phenomenon. The findings of this study may lay the foundation for nurses and other professionals to develop prenatal care plans and policies that are culturally congruent and consistent with the needs and desires considered important to promote positive experiences of care.

Chapter 2

Review of the Literature

2.1 Ethnohistory

In 1619, the first Africans were brought to America to be indentured servants and eventually slaves for British colonies in Jamestown, VA (History, 2012; Pbs, 2004). It has been estimated that during the 18th century some six to seven million slaves were brought from Africa and sold in the New World (History, 2012). Slavery was abolished in the Northern states by the end of the 18th century, but slavery continued to be a lucrative business for Southern rice, tobacco, and indigo plantations (History, 2012). The importance of slavery to the South's economy was further solidified in 1793 when Eli Whitney invented the cotton gin, expediting cotton processing, and virtually saving the South from the economic ruin of tobacco farming (History, 2012; Pbs, 2004). Although the import of new slaves was outlawed by Congress in 1808, southern states continued domestic trade of American-born slaves to cotton-growing states across the lower South and the West (Pbs, 2004). By 1865, when the Thirteenth Amendment to the U.S. Constitution officially abolished slavery, the U. S. population of slaves surpassed four million, with over half of them living in southern states (History, 2012).

Slavery did not occur in the free territories in the Pacific Northwest (Caldbick, 2010). The earliest known Afro-Americans (African Americans or mixed race people) arrived in the area in the 1840s (Taylor, 1982). According to the 1870 census data, there were 207 people of color (blacks or mixed race) living in Washington Territory (Caldbick, 2010) Although racial hostility and discrimination were evident in the Pacific Northwest, Washington territory remained a slave-free state when it gained statehood in 1889 (Caldbick, 2010; Taylor, 1991). The African American population surged around the state as former slaves migrated west in search of

better living conditions and jobs. Most lived in the Seattle area, but in 1940s, the African American population in Tacoma, an area south of Seattle, surged from 650 to 3,205 by the war's end as African Americans from the Deep South found employment in the war plants during the defense buildup for World War II (Wilma & Crowley, 2006). After the war, the African American population in this area continued to grow as many people found jobs at military facilities in the area. Today, the Puget Sound area has the largest population of African Americans in the Washington, 12.9 percent of the total population, and is home to a large joint military base and within one to two hours of four other military bases (Bureau, 2011; Rastogi, Johnson, Hoeffel, & Drewery, 2011).

2.2 Healthcare Disparities

The health disparities that exist between African American women and women of other races are alarming. Among African American women 18 years and older, the five leading causes of death, in rank order, are heart disease, malignant neoplasms, stroke, diabetes, and nephritis (U.S. Department of Health and Human Services, 2011b, p. 27). Hypertension ranked tenth, but combined with diabetes, stroke, and heart disease, it continues to be a major risk factor for cardiovascular disease (CVD) (Roger et al., 2012; Services, 2012a, p. 27). The prevalence of CVD in African American females is 47.3 percent, compared to 33.8 percent in white females and 35.0 percent among all females in the United States (Roger et al., 2012, p. e29). Compared to White women, African American women are twice as likely to be diagnosed with diabetes (Roger et al., 2012). The rates of admissions for uncontrolled diabetes and amputations from diabetes were higher for African American women than White women (Services, 2012a, 2012b).

Women's health concerns show an even direr situation. In 2008, although African American women over 50 years old were more likely than women of other races to receive a

mammogram, those 40 years and older were more likely to have breast cancer diagnosed at more advanced stages, and overall, African American women are more likely to die from breast cancer (Services, 2012a). African American women are also more disproportionately affected by HIV/AIDS than women of all other races. In 2009, the rate of new HIV cases among African American women was 47.8 per 100,000 women, and the rates of new AIDS cases was 35.1 per 100,000 women. Sadly, these rates are more than 20 times the rates of White women (Services, 2012a, p. 4; U.S. Department of Health and Human Services, 2011b, p. 41). In 2008, death from HIV was one of the five leading causes of death among African American women age 25-54 years old (Heron, 2012).

2.3 Issues of Trust in Healthcare and Research

African Americans have a long history of distrust in healthcare providers and research. Much of the research on African Americans and distrust focused on the Tuskegee Syphilis Study 1932-1972 that involved 399 African American men who thought they were being treated for "bad blood," but who actually had untreated syphilis (Gamble, 1997, 2006; Prevention, 2011). The purpose of the study was to document the natural history of the disease on the body; however, even after Penicillin became the gold standard for treatment in 1947, the men were still not offered treatment (Gamble, 1997; Prevention, 2011). This "ethically unjustified" study fueled African American's distrust in medical and public health authorities, and has been cited as a reason for low participation in research studies (Gamble, 1997).

The true impetus for distrust may predate the Tuskegee study and arise from the institution of slavery and the use of slaves and free blacks as subjects for experimentation, the illegal acquisition of the deceased robbed from graves for the purpose of medical dissection, and the history of racial discrimination and exploitation (Corbie-Smith, Thomas, & St. George, 2002;

Earl & Penney, 2001; Gamble, 1997; Humphrey, 1973). To rationalize the use of African slaves over white laborers, numerous experiments were conducted on slaves to evaluate their endurance to the harsh conditions of southern plantations (Savitt, 2005). Slave owners also cited the need to have doctors adequately treat "black diseases" and to discover why blacks had "immunity to certain diseases that devastated whites" as reasons for experimentation (Savitt, 2005, p. 14). Dissection of the human body was considered a "degrading and sacrilegious practice" and was illegal; however, the marginal and powerless Blacks could not protect their dead from being stolen from their graves (Humphrey, 1973, p. 819). Additionally, slaves were considered property and denied the legal right to refuse participation (Gamble, 1997). The health of the slaves determined the economy of the plantation; therefore, slave owners were more apt to partner with physicians who, in the process of advancing their medical procedures, techniques, and treatments, could also return the slave back to the business of laboring the plantation. Slave owners preferred that slaves be treated by white physicians rather than allowing them to use traditional African treatments. Savitt (2005) reported that slaves submitted their bodies to their owners and white treatments, which often consisted of the "application of cups, leeches, and lancets," and the "excessive use of purges, vomits, sweats, and diuretics" (Savitt, 2005, p. 16). Free African Americans were not immune from experimentation. They seldom had the funds for healthcare and often sought free treatment in teaching facilities or other dispensaries where care was either inadequate or unnecessary, but done for demonstration purposes (Wasserman, Flannery, & Clair, 2007, p. 178).

After Congress outlawed slave importation, the importance of slave women on plantations was an economic advantage on two levels; slave women not only labored the plantation, they also reproduced. Often sold as a "breeding wench," young slave women were

valued for their ability to reproduce early and often, about every two and a half years (Hallam, 2004; Schneider & Schneider, 2007, p. 52). Slave owners often promised women freedom if they bore a certain number of babies (Schneider & Schneider, 2007, p. 52). Childbearing came with many risks including creating a vesicovaginal fistula or an abnormal opening between the bladder and vagina causing uncontrollable urinary incontinence, or a rectovaginal fistula, an abnormal opening between the rectum and vagina causing fecal incontinence. These devastating conditions deteriorated the usefulness of the slave woman. As noted above, slave owners "supported the physician's claim to professional status, just as doctors upheld the idea of the slaveholder's right to claim human property" (Schwartz, 2006, p. 269). On the other hand, slave women valued motherhood because they were less likely to be sold, received more food, and the children could help with the labor, so any treatments to "fix" their "afflictions" were not refused (Schwartz, 2006). These two ideas culminate in the controversy surrounding Dr. J. Marion Sims, the father of modern gynecology, who between 1845 and 1849, performed up to 30 surgeries on three unanesthetized slave women who were suffering from vesicovaginal and/or rectovaginal fistulas (Gamble, 1997; Wall, 2006). Wall (2006) suggested that although historians would argue the slaves were not afforded the option to object to the surgeries because they were slaves, he suggested that they may not have resisted, despite the pain, because Sims was improving their lives. Wasserman, Flannery, and Claire (2007) suggested that Sims may have been simply operating in the sociological context of slavery. Regardless of the position taken, it is documented that only after the techniques have been perfected did doctors perform the repairs on white women volunteers (Gamble, 1997; Schwartz, 2006).

The consequences of distrust have greatly impacted treatment seeking and health promoting behaviors, such as avoiding treatment or using alternative therapies that may be

incompatible with the health situation. Earl and Penney (2001) found that African Americans lacked trust in researchers and the informed consent process because they have little confidence in the researchers' honesty or reliability (p. 753). Gamble (2006) described trust as the "cornerstone of the provider-patient relationship", the basis for quality health care delivery and outcomes (p. 437). The erosion of trust among minorities thwarts efforts to improve health and decrease disparities (p. 437). Gamble (2006) identified two categories of trust which may impact health care. *Interpersonal trust* occurs between individuals like a patient and provider (p.438). Trust is a repetitive process from selection by referral to multiple interactions with the provider (Corbie-Smith et al., 2002, p. 2462). This trust allows a patient to share health concerns and receive recommendations to improve health. *Social trust* refers to the trust and belief that people, institutions, hospital, healthcare, or health plans will advocate for people in a manner that is consistent with their interests (Corbie-Smith et al., 2002, p. 2462; Gamble, 2006, p. 438). Interpersonal and social trusts are not mutually exclusive, but are interdependent. A person can have trust in a provider without trusting the healthcare system, or trust the healthcare system and not the provider. Trust is a dynamic process that is ongoing and dependent upon consistent positive relationships. Life circumstances, social situations, and any other challenges can affect a person's ability to trust.

2.4 Prenatal Care

Evidence has linked early and continuous prenatal care with more positive maternal, fetal, and neonatal outcomes (Alexander & Kotelchuck, 1996; Fiscella, 1995; Hueston, Gilbert, Davis, & Sturgill, 2003); however, this evidence remains controversial because there are multiple definitions of prenatal care and utilization, and randomized clinical trials of prenatal care versus no prenatal care would be unethical (Alexander & Kotelchuck, 2001). Prenatal care

is most commonly defined as the medical care a woman receives from a doctor, midwife, or other health professional during a pregnancy. Several researchers used the Health Belief Model as the theoretical framework to define prenatal care as a preventive health behavior motivated by a woman's belief about the need for care and concern for fetal well-being (Fuller & Gallagher, 1999; Tiedje, Kingry, & Stommel, 1992). The Institute of Medicine (IOM) and the American Congress of Obstetrics and Gynecology (ACOG) recommend defining prenatal care based on utilization and "adequacy" (Alexander & Kotelchuck, 1996, 2001; Fiscella, 1995); however, these indices differ in what they deem adequate with respect to the number of attended prenatal visits, and the indices cannot be used interchangeably to evaluate prenatal care in different populations (Alexander & Kotelchuck, 2001). According to the ACOG, "adequate" prenatal care is defined as care which begins in the first trimester and includes at least nine visits. Frequency of prenatal care visits is determined by the health care provider and is dependent on the woman's individual needs and risk factors. Among high risk women, early initiation and continued utilization of prenatal care increases the potential for health concerns to be identified and provides an opportunity for implementation of risk-reducing measures.

Kotelchuck's Adequacy of Prenatal Care Utilization (APNCU) Index is a more sensitive indicator of prenatal utilization; the APNCU combines timing of prenatal care initiation with the frequency of visits received after initiation (A. Johnson et al., 2007). Prenatal Care beginning in the fourth month of pregnancy is classified in the following manner: (a) *Adequate Plus*: women made 110 percent or more of expected visits; (b) *Adequate*: women made 80 percent-109 percent of expected visits; (c) *Intermediate*: women made 50 percent-79 percent of expected visits; and, (d) *Inadequate*: women made less than 50 percent of expected visits (A. Johnson et al., 2007; Kotelchuck, 1994). Alexander and Kotelchuck (2001) attempted to define prenatal care

conceptually in terms of utilization, content, and quality, but noted that "the benefits of prenatal care may not be equivalent for all population subcultures" because prenatal care varies across socioeconomic, demographic, medical, and cultural risk groups, and among different women (p. 116). Content and quality are controversial because they are provider and facility dependent. Fiscella (1995) suggested defining prenatal care as an intervention that consists of a series of assessments and appropriate treatments for pregnant women in ambulatory settings, and suggested measuring its impact by outcomes such as low birth weight and preterm birth rates.

2.5 Prenatal Care and African American Women

There is a wealth of knowledge evaluating prenatal care utilization and barriers to care among African American women, but no research has evaluated culture care as a factor to improving prenatal care utilization. Morgan (1994) used Leininger's theory to evaluate prenatal care among African American women within their familiar cultural contexts to discover knowledge that could be used by health professionals to provide culturally congruent prenatal care, but no other dissertations have been conducted since that time. In the military, very few studies have been conducted on prenatal care use, the most recent was 11 years ago, and none of these studies included cultural considerations for care. With the advent of patient and family centered care, it is imperative that a person's culture be incorporated into the care planning to make the care more meaningful to the person receiving care.

A systematic search of the literature using EBSCOhost, ProQuest, OVID, Medline, Pubmed, PsychINFO, and Cumulative Index to Nursing and Allied Heath Literature (CINAHL) computerized databases was conducted to identify articles that related to African American women and pregnancy. Because of the scarcity of current military literature on this topic, the timeframe was unspecified in order to identify all studies that contained the following search

terms: *African American, Black, women, minority women, military, pregnancy, prenatal care, prenatal period, birth*, and *beliefs***.** Twenty studies were examined, including five military studies, but after careful review, 11 studies, including one military, were accepted because they met the following criteria: (a) focused on prenatal care, (b) included African American women, and (c) were published in English in a peer-reviewed journal.

In the accepted studies, sample sizes ranged from 16 to 2,222,044 women. Three of the studies included White, Hispanic, and African American women. The military study included active duty service women and family members. A variety of qualitative and quantitative data collection techniques were used including retrospective analysis, surveys, personal interviews, and focus groups. White women had the most favorable birth outcomes; African Americans had the least favorable outcomes (Baldwin, Grossman, Casey, & Hollow, 2002). Themes that emerged from the qualitative studies relating prenatal care and African American women were *take care of self, racial/cultural insensitivity and trust, considering abortion/pregnancy wantedness, community and family support, and known barriers to care.*

Adequate and inadequate PNC users shared motivators to have healthy babies, learn better health habits, and understand how to improve their health (A. Johnson et al., 2007, p. 627). Women were also motivated to seek PNC by friends, family, and their desire to increase their social support to minimize depression, ambivalence, and isolation (Edmonds, Mogul, & Shea, 2015). Women wanted to take care of themselves and decisions regarding prenatal care use were based on self-care needs and behaviors (Sword, 2003). Paradoxically, Johnson et al. (2007) found that one of the biggest obstacles to PNC was being able to "take care of self" because prenatal care was accessed only when women needed help rather than because there was value to the care received. Early and/or adequate PNC visits were least used by women who had

experienced a prior pregnancy because they knew how to take care of themselves during their pregnancies and were "knowledgeable about pregnancy" (Daniels, Godfrey Fuji, & Mayberry, 2006; Meikle, Orleans, Leff, Shain, & Gibbs, 1995). "I didn't follow-up on my appointments now… I'm on number five (Daniels et al., 2006, p. 194)." Care staff did not always view this attitude positively. Daniels et al. (2006) also noted that having prior pregnancy experience also resulted in women feeling "belittlement and shame" from insensitive staff who made sarcastic comments like "you pregnant again" or "oh, baby you just had a baby last year… let's get your tubes tied" (p. 195).

Minority women also cited cultural insensitivity and staff attitudes as barriers to PNC (Daniels et al., 2006; Phillippi, 2009). Women who perceived that providers and nurses treated others unfairly because of their race delayed PNC initiation 4.2 weeks on average compared to their counterparts who did not have that perception (Richardson, Rhodes, & Singleton, 2009). Those who thought that the providers and nurses demonstrated strong anti-minority bias delayed PNC initiation by 2.4 weeks (p. 229). Women whose primary language was Spanish initiated care two weeks later than those whose primary language was English (p. 228). Regardless of race or ethnicity, women seeking access to prenatal care distrusted health care professionals who had strong anti-minority bias and those who were known to discriminate or treat others differently because of minority status (Richardson et al., 2009, p. 229; Sheppard, Zambrana, & O'Malley, 2004, p. 487; Sword, 2003, p. 326).

Providers who listened, took the time to address all of their questions and concerns, communicated clearly, and were nonjudgmental and respectful promoted quality patient-provider interactions (Lori, Yi, & Martyn, 2011; Sword et al., 2012). Women wanted correct health information and acknowledgement for what they knew about their health, and they preferred an

active role that was client-centered and allowed them to control their situations. Continuity of care with a provider enabled women to establish a trusting relationship and optimize the visit because the provider knew them (Lori et al., 2011). Through repeated interactions with the same provider, the interpersonal trust that developed between patients and providers allowed patients to evaluate the trustworthiness of the provider and to share health concerns and receive recommendations to improve health (Gamble, 2006; Peters, Benkert, Templin, & Cassidy-Bushrow, 2014).

"Considering abortion" and previous abortion experience were important factors influencing early versus late prenatal care initiation among African American women across four studies (A. Johnson et al., 2003; A. Johnson et al., 2007; J. Johnson, Primas, & Coe, 2007; Phillippi, 2009). According to Meikle, Orleans, Leff, Shain, and Gibbs (1995), Black and Hispanic women most frequently reported that they did not seek early prenatal care nor had late prenatal care because they did not want to think about the pregnancy. Of the 88% of the women who knew they were pregnant within four months of conception, 36% still did not go for prenatal care by six months (p. 85). African American women "didn't think it was important" (p. 83). Consistent with this study, Daniels, Noe, and Mayberry (2006) found that although African American women considered prenatal care to be important, it was just not important to their current pregnancy or as important as other daily life issues. Pregnancy "wantedness" was a psychosocial barrier to prenatal care that was found in three studies and determined whether women sought early prenatal care (Daniels et al., 2006; A. Johnson et al., 2003; A. Johnson et al., 2007). Conversely, early initiation of PNC (before 20 weeks gestation) was not predictive of adherence to future scheduled visits. Johnson et al. (2007) found that among 147 African American women who had inadequate PNC use based upon the Kotelchuck's Adequacy of

Prenatal Care Utilization (APNCU) Index, 61 women actually initiated PNC early (before 20 weeks gestation), but did not adhere to subsequent visits; 36 women initiated prenatal care after 20 weeks gestation and kept subsequent visits; and, 50 women did not receive early care or adhere to subsequent visits (p. 624).

Sheppard (2004) discussed using lay health workers (LHW) or resource mothers to "extend prenatal care into community setting and link underserved women to necessary health and social services" (p. 485). The authors found that support provided by LHW improved the PNC experience, specifically promoting a mother-to-mother relationship that increased trust, access to care, knowledge, and continuity (p. 489). Sanders-Phillips and Davis (1998) suggested a reevaluation of the content and objective of prenatal care, to include alternative approaches such as site where care can be offered that would be more convenient for the women seeking care (p. 22). Sites would include welfare offices, food programs, schools, or churches. Two studies found that women who participated in WIC or received public assistance had higher rates of early and adequate prenatal care utilization (Frisbie, Echevarria, & Hummer, 2001; A. Johnson et al., 2007).

Klerman et al. (2001) evaluated an "augmented care" program which was designed for high-risk Medicaid-eligible, African American women. This program provided group prenatal care to women and fostered social support from family, close friends, and the father-to-be; promoted culturally congruent care through staff encounters and available resources; provided on-site child care; and, employed evening appointment times (Klerman, Ramey, Goldenberg, Marbury, & et al., 2001). The researchers found that the participants had increased patient satisfaction, knowledge of pregnancy, and perceived mastery of her life (p. 110).

Encouragement to enter PNC by family members and having childcare offered by family members and friends were found to be significant indicators of whether PNC would be initiated early or late (A. Johnson et al., 2003; Meikle et al., 1995). In a later study, Johnson et al. (2007) found that having social support promoted a positive attitude toward prenatal care; conversely, women with negative attitudes toward prenatal care were more likely to receive pregnancy-related advice from family and friends. These women would also go to the emergency department when problems in pregnancy occur rather than seek care with a prenatal care provider (p. 624). The significant other also influenced prenatal care attendance, as women made "deals" that, if their significant others attended prenatal care visits, they would go; otherwise, they would wait until their mates could attend (Daniels et al., 2006, p. 195).

Although white women have been considered to have higher incomes than Black and Hispanic women, and are therefore expected to have fewer financial constraints to seeking early prenatal care, Meikle, et al. (1995) found that White women were more likely to report financial concerns. Health insurance coverage and primary language were significant indicators of early initiation of PNC (Richardson et al., 2009). Lack of insurance coverage delayed prenatal care initiation by 4.3 weeks (Richardson et al., 2009, p. 231).

Long wait times were concerns of many women who presented late to prenatal care (A. Johnson et al., 2007). "My first visit it took 5 hours to see me…That's why I just stayed home next time" (Daniels et al., 2006, p. 194). Novick (2009) suggested that women may decide that the benefits of receiving PNC may not outweigh the long wait times required to obtain the care. Having convenient clinic hours was found to significantly impact PNC utilization among adequate and inadequate PNC users (J. Johnson et al., 2007, p. 627).

Babysitting problems, the belief that prenatal care attendance is required only in the event of present or past problems with pregnancy, fear of medical procedures, and dislike of physical/pelvic examinations and blood draws were additional barriers to care (Mikhail, 2000; Phillippi, 2009). Depressive factors, powerlessness, alcohol problems with close family members, arrest of close family or friend, and history of sexual or physical abuse were the most common psychosocial factors influencing entry to PNC (Daniels et al., 2006; Meikle et al., 1995). Twenty-four percent of the women who did not seek prenatal care revealed that at some point in their lives, they had thoughts about or attempted suicide (Meikle et al., 1995).

To date, there has been only one military study that investigated racial disparities in outcomes in military and civilian births. Barfield et al. (1996) retrospectively analyzed 2,222,044 records over five years. The study included 79,154 records of women who received care in a military hospital, of which 12,807 records were from African American women. The researchers found that only 75.1% of African American women began PNC in the first trimester compared to 79.3% white women. The percentage of black and white women who began care in the third trimester or had no PNC at all was significantly larger than in the civilian population (p. 1063). Despite having access to free prenatal care in the military health facility, the problem of late/no initiation of care existed among African American women within the MHS.

2.6 Synthesis of the Literature

Review of the literature revealed several themes related to prenatal care utilization among African American women. According to the research, African American women understood that prenatal care and taking care of themselves were important; however, they reported numerous barriers that delayed entry into care services. Significant to early entry into prenatal care services was whether the pregnancy was wanted or considered as important as other life issues the

women were facing at the time. Women who considered themselves knowledgeable reported that they delayed care to deal with other more pressing life events. When women did seek care, trust and racial and cultural insensitivity were barriers to continued prenatal care use. Considering the history of African Americans in the United States, and the complex worldviews of being African American and women, it is not unrealistic to believe that the women would rather stay home and not endure ridicule at the provider's office. The establishment of trust is important to health care, and when women do not feel that they can trust the provider to adequately care for them, they are less likely to utilize health care options, regardless of how important they know this care is for the pregnancy outcome. Johnson et al. (2007) found that African American women sought support from family, friends, and significant others rather than go for prenatal care. This finding could also be affected by the long wait times, but a combination of factors at any given time appear to contribute to inadequate prenatal care utilization. For women associated with the military, low prenatal care utilization existed despite the fact that they had access and no financial barriers to health insurance coverage. There were no studies that sought to hear their voices and determine what other factors are influencing prenatal care utilization. This study is designed to allow these women's voices to promote the discovery of knowledge that may fill the gap regarding culture care and the African American military women and female spouses' experiences of care during the prenatal period.

2.7 Theoretical Framework Orientation Using Leininger's Theory of Culture Care Diversity and Universality

The theory of culture care diversity and universality will provide the theoretical orientation for understanding military African American women and female spouses' experiences of care during the prenatal period. The purpose of the theory is to "discover,

document, know, and explain the interdependence of care and culture phenomena with differences and similarities between and among cultures" (Leininger, 2006, p. 4), and to discover culturally based care factors which can influence the health, well-being, illness, or death of individuals or populations (Leininger, 2002, p. 189). Leininger and McFarland (2002) maintained that "the universality of culture care was based on the philosophical belief that all human beings needed care to survive" (p. 73). Diversity was "based on the belief that human beings were born, raised, and showed differences or variabilities from universal or common care features" (p. 73). For nurses to provide the most culturally congruent care to people, they needed to discover the similarities and diversities about human care within different cultures. The theory focuses on the belief that culturally diverse people can inform and influence professionals to provide them the kind of care they desire or need from others. It is also directed toward discovering and using culturally-based care knowledge obtained from cultural informants (Leininger, 2006, p. 8). The cultural informants' *emic* (insider) knowledge about care is deeply valued, and "the researchers' goal is to obtain the worldview, attitudes, meaning, and experiences of the people so that truths and realities can be known" (p. 8). The *etic* (outsider) view is 'formal and explicit cognitively learned professional care, knowledge, and practices obtained general though educational institutions" (p. 8).

Leininger (1985, 2006) predicted three actions and decision modes which can be used to promote prenatal care utilization among and provide prenatal care that is culturally congruent, safe, and meaningful for American women. *Culture care preservation and/or maintenance* refers to supportive, assistive, and facilitative, or enabling actions and decisions which help cultures preserve or maintain meaningful care values and lifeways, recover from illness, or cope with handicaps or death (Leininger, 1985; 2006, p. 8). *Cultural care accommodation and/or*

negotiation refers to supportive, assistive, and facilitative, or enabling professional care actions and decisions which help people adapt to or negotiate with others for meaningful, culturally congruent, and beneficial health outcomes (p. 8). *Cultural care repatterning and/or restructuring* refers to supportive, assistive, and facilitative, or enabling professional actions and decisions that help people change, reorder, or modify their lifeways for new, different, and beneficial health patterns, practices, or outcomes (p. 8). When the three modes action and decision modes are creatively used and thoughtfully developed, the researcher would meet the goal of providing culturally congruent care that was tailor made to fit the worldview, societal structure factors, and other cultural dimensions valued by the care recipients (Leininger, 1997; Leininger & McFarland, 2002).

2.8 Summary

This chapter explored the ethnohistory of African American women and the overall effects of slavery, experimental and unethical treatment, and mistrust on their willingness to participate in or obtain prenatal care. The scarcity of literature available related to African American women precluded an examination of the potential effects of ethnohistory on the high rates of no/low/late prenatal care use among African American women. There is clearly a need to hear the voices of African American women regarding their experiences during the prenatal care period, and Leininger's theory of cultural care diversity and universality is the most fitting theoretical framework to explore holistic factors that may influence their view on the world, health, and prenatal care. Research focused on the women's experiences and understanding the differences (diversity) and similarities (universality) in traditional (emic) and professional (etic) care practices is necessary to promote prenatal care experiences that are culturally congruent and meaningful to these women.

Promoting trust during prenatal care is paramount to building shared partnerships where women are actively involved in their care and empowered to continue seeking care beyond the pregnancy; however, an understanding of the beliefs and traditions which guide her prenatal care seeking behaviors is vital to building trust. Mutual partnerships have to occur between the health care provider and clients in order for the clients to take an active role in health seeking behaviors, goal setting, and decision-making. The partnership is flexible, with the health professional recognizing that the client may temporarily entrust control of their health back to the health professional while the client assesses how new information can improve their current situation. Through self-determination, they define the goals that are important to their own quality of life and negotiate with the healthcare provider about the information and skills needed to make changes in their lives. Trust allows women to express her joys, fears, wants, and desires for her pregnancy without her feeling that she would be criticized or labeled as resistant to care. Cultural variations in women's views should be considered in development of programs intended to improve prenatal care (Meikle et al., 1995).

Chapter 3

Method

3.1 Ethnonursing Method

The ethnonursing method was designed and created by Dr. Madeleine Leininger (1985) to work in concert with the theory of cultural care diversity and universality and to discover the lifeways of people from their unique cultural experiences. Ethnonursing is a rigorous, systematic, and in-depth approach for studying multiple cultures and care factors within the people's own world, focusing on the interrelationships of care and culture to achieve the goal of providing culturally congruent care (Wehbe-Alamah & McFarland, 2015a). Ethnonursing allows researchers to discover the "care factors within familiar environments of people, and to focus on the interrelationships of care and culture to arrive at the goal of culturally congruent care services" (Leininger, 2006, p. 20). This is an appropriate method to use when there is no or very limited knowledge about a transcultural nursing phenomenon. There was adequate information to support the fact that overall African American women have high rates of no/low/late prenatal care; however, when women have no financial barriers to health insurance coverage, research was needed to understand why this phenomenon still existed.

In ethnonursing research, data collection traditionally occurs through the use of individual interviews with key and general informants. Leininger (2006) defined key informants as those most knowledgeable about the domain of inquiry; in contrast, general informants only have general knowledge and are used to show how similar or different their ideas are to the key informants (Wehbe-Alamah & McFarland, 2015a). General participants are willing to share information and knowledge in relation to the domain of inquiry though they may not be as fully knowledgeable as the key participants. Key informants are the main source for checking the etic

and emic relevance, meaning, accuracy, and dependability of data collected (Wehbe-Alamah & McFarland, 2015a). Leininger considered the information from general participants essential to show how similar or different the ideas were to the key participants (Wehbe-Alamah & McFarland, 2015a); however, the depth of information that can be discovered from key informant's individual and focus group interviews could illustrate the diversity and universality of the domain of inquiry. Additionally, offering focus groups as an option for data collection has potential in assessing sensitive issues from culturally diverse viewpoints (Lambert & Loiselle, 2008) and may be more congruent with the communication methods of some cultural groups. Focus groups can "bring the researcher closer to the research topic through a close and intense encounter with key individuals" (Clarke, 1999) and allow the researcher to listen to the perspective of key stakeholders and learn from their experiences of the domain of inquiry (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007).

Three enablers were used in this study: sunrise enabler (Appendix A), observation-participation-reflection (OPR) enabler, and stranger-to-trusted friend (STF) enabler. The sunrise enabler identified factors that needed to be studied with the theory of cultural care and was used as a major guide throughout the study to explore comprehensive and multiple influences on care and culture (Leininger & McFarland, 2002, p. 79). It generated knowledge concerning basic and applied health and illness and provided a way to better understand the factors that influence culture and care (p. 24). The sunrise enabler reminded the researcher to search broadly for diverse factors that could influence care within any culture being studied and that need to be considered in relation to the theory and domain of inquiry (p. 20). The OPR enabler was used during observations of African American women at various locations on the military bases and during group prenatal care sessions. According to Leininger and McFarland (2006), when

conducting research, the STF enabler is used from the beginning to end, and guides the researcher who "enters the world of the participants to learn about care meaning and practices" (pp. 26-27). Becoming a trusted friend increases the probability that participants would be willing to share sensitive, meaningful, accurate, and credible data. Leininger (2002) noted that the process of moving from stranger to trusted friend "takes time and keen sensitivity while showing a genuine interest in the participants" (p. 92).

Prior to beginning the study, the researcher (T.H.S.), who is an African American military Certified Nurse-Midwife (CNM) from Charleston, South Carolina, recognized the importance of being aware of preconceived notions about African Americans, PNC, and group interactions that could hinder discovery of new information. Plowden and Wenger (2001) suggested using the concepts *unknowing*, *reflection*, *presence*, and *knowing* as one moved from stranger to friend and became observant of the cultural lifeways of people and of what was actively and passively occurring. In *unknowing*, the researcher sought exposure to new experiences. The goal was to allow the participants to "teach me" about them. *Reflection* sought to discover "what is going on here?" and required the researcher to be aware of and reflect on all aspects of the women's experiences. She could not assume that because she was an African American CNM, the women would be more willing to interact or share with her or she knew the women's experiences. To have *presence* was to be in the moment, available to the participants, and engaged in their environment. In *knowing*, the researcher acknowledged the real environment and gained an understanding of the participant's lifeways.

3.2 Focus Groups and African American Women

The focus group is a data collection method in which the opinions, values, and beliefs of participants are expressed collectively and individually and interactions between the participants

are analyzed (Halcomb et al., 2007). Group interactions might accentuate member's similarities and differences and give rich information about the range of perspectives and experiences (Lambert & Loiselle, 2008). Focus groups have been used to draw information from members of diverse and vulnerable populations who are normally hard to reach, including disadvantaged and disenfranchised people (Liamputtong, 2011). Participants are able to express their views and needs so that culturally sensitive and appropriate interventions may be developed (Liamputtong, 2011). When used in research with minority and multicultural groups, focus groups may provide a better understanding of consumer needs, culturally diverse perspectives, and people's experiences of a phenomenon so that culturally sensitive and appropriate interventions may be developed (Halcomb et al., 2007; Liamputtong, 2011; Secor-Turner, Sieving, Garwick, Spratt, & Duke, 2010).

Gathering together and sharing family stories are inherent to African American culture. These time-honored practices and traditions allow African-Americans to reflect on and preserve the family's culture and history, share information that is important to future families, and reaffirm an unwavering commitment to the family. Data collection methods such as group interviews, observation, and participant observations capture the holistic factors that impact their everyday lives (Secor-Turner et al., 2010). When used in research involving African American women, focus groups allow them to gather together and share information related to the domain of inquiry, and can bring forth detailed data about their experiences that may not be discovered with individual interviews alone.

Focus groups and individual interviews have been used in studies with African American women to explore a range of phenomena. Bruening, Pastore, and Armstrong (2008) used focus groups and individual interviews to explore factors influencing African American women's

participation in sports. Focus groups allowed the participants to be involved in the research process, established rapport between the interviewer and participants, and facilitated a free-flowing exchange of information (Bruening, 2004; Bruening et al., 2008). These data collection methods were also used to explore midlife African American women's risk taking and protective practices against HIV/AIDS (Mallory, Harris, & Stampley, 2009), experiences of African American women who provide care to family members living with HIV/AIDS (Tolliver, 2001), and the relationships between health, hunger, and food insecurities among African American women (Chilton & Booth, 2007). Harley et al. (2009) used individual interviews and focus groups to study African American women's initiation and continuation in a physical activity program. The authors disseminated preliminary findings from individual interviews to the focus groups and used member checking to ensure the findings represented the participant's experiences.

In studies exploring African American women and prenatal care, focus groups and individual interviews were used to examine the experiences of racial discrimination during prenatal care (Salm Ward, Mazul, Ngui, Bridgewater, & Harley, 2013). Focus groups were used as the sole data collection method in research studies that examined factors affecting prenatal care attendance and preferences for prenatal care experiences among low-income African American women (Edmonds et al., 2015), provider characteristics that pregnant African American women considered important during prenatal care (Lori et al., 2011), and barriers to prenatal care among African American women of low socioeconomic status (Daniels et al., 2006). During the focus groups, participants were candid about their beliefs and thoughts about pregnancy, prenatal care, and factors that affected their actions toward the developing fetus (Daniels et al., 2006). The discussions were informative and comprehensive, gave voices to

people who have been under-represented or marginalized, and allowed the participants to present their own views while interacting with and commenting on the experiences of others (Daniels et al., 2006; Salm Ward et al., 2013).

3.3 Focus Group Considerations

Focus groups are usually homogenous and consist of four to ten participants meeting one to three hours; however, smaller sized groups may be effective when discussing complex issues (Jayasekara, 2012). The location of the focus group should allow the participants to be relaxed and comfortable, and should be accessible to all involved (Clarke, 1999). The less structured the group, the greater the potential for the emergence of concerns that are relevant to the members (Stevens, 1996). Participants can initiate ideas without the fear of personal scrutiny that may occur in individual interviews because the ideas belong to the group rather than the individual (Stevens, 1996). During the group, participants build on the answers of others, often generating new and spontaneous ideas that the researcher did not think of before or during the interview (Holloway & Wheeler, 2009). The researcher must remain unobtrusive, encouraging the participants to freely express their points of view (Clarke, 1999; Lane, McKenna, Ryan, & Fleming, 2001).

Inherent in the focus group method is the potential for one member to dominate the conversation; however, the strengths of synergy and collective insight from the participants provide richer data that may not be collected from individual interviews (Stevens, 1996). Although group participants feel more free to engage in conversations about sensitive or social stigmatized events because they realize that they are not alone and that others have had similar experiences (Stevens, 1996), it is also possible the participants may give socially acceptable answers rather than honest answers about their experiences (Clarke, 1999).

3.4 Adapting the Ethnonursing Method

According to Leininger, research methods of the same paradigm may be combined if they fit the study purpose and the reason for combining the methods are made clear at the onset and with the domain of inquiry (Leininger, 1990; Wehbe-Alamah & McFarland, 2015a). The ethnonursing method has been combined with focus groups, phenomenology, ethnography, and life histories (Leininger, 2006; M. McFarland, Mixer, Wehbe-Alamah, & Burk, 2012; Wehbe-Alamah & McFarland, 2015a). Focus groups and interviews provide detailed understandings of the issues that are important to the key participants (G. Novick, 2009), and facilitates discovery of factors from their perspectives that influenced the domain of inquiry. Focus groups can capture the social and cultural contexts that inform individual's experiences (Secor-Turner et al., 2010). When there are considerable gaps in the literature related to a phenomenon, particularly the experiences or perceptions of people, hearing only the voices of those who were directly involved or impacted by the domain of inquiry has the potential to provide deeper insight and understanding when compared to the perceptions of others. Focus groups not only explore what participants have to say, but also provides insight into the sources of complex behaviors and motivations (Jayasekara, 2012).

Focus groups and key informant interviews can "elicit information that is rich in context, meaning, and details" (Orlowski, 2014, p. 184), but the researcher must consider the rationale for using both methods. Lambert and Loiselle (2008) identified three rationales for using focus groups and individual interviews: (1) *pragmatic reasons*: offers participants the flexibility to choose the method in which they prefer to participate, (2) *compare or contrast (parallel use)*: each method is used with different groups of participants and the data from one method does not influence the other; and (3) *data completeness and/or confirmation (integrated use)*: data

completeness assumes that each method reveals complementary views of the phenomena of interest, while confirmation assumes that the findings of one method will corroborate the findings of the other method. The researcher will determine which data collection method to use first; however, focus groups may be used later to validate themes that emerge from individual interviews.

3.5 Setting

This research study took place at two military medical treatment facilities (MTF) in the Puget Sound area of Washington, where the African American population is 12.9 percent (U.S. Census Bureau, 2011). Washington's African American population is 3.8 percent (U.S. Census Bureau, 2010).

3.6 Participants

Individual interviews were initially used for data collection and continued until data saturation occurred. Purposive and snowball sampling were used in recruitment. Purposive sampling was used at the beginning of recruitment because the researcher hoped to identify participants who were willing to refer other women who met the inclusion criteria and were interested in participating in the study. At the beginning of the study, the researcher spent one week at one of the MTF attending group prenatal care sessions and explaining the purpose of the study. She was also available to conduct interviews. Women were invited to participate in individual interviews and/or focus groups. Participants who wanted to be involved in the study after they have had their babies were given contact information for the researcher. The researcher was available full-time at one MTF and two days a week at the other facility. Women who meet following inclusion criteria will be invited to participate in the study:

1. Non-pregnant females ages 18 to 40 years with prior prenatal experience in the last 15 years
2. Currently on active duty in any branch of the military or the spouse of an active duty military member
3. Identifies self as African American
4. Prior prenatal care in a military or civilian facility in the U.S. or abroad
5. Willing to participate in the study
6. Agrees to participate in one interview and/or a focus group

3.7 Participant observations

The researcher used Leininger's ethnonursing observation-participation-reflection (OPR) enabler to observe African American military women and spouses at various locations on the military bases and during group prenatal care sessions. Observations allowed the researcher to observe African American women's interactions with each other, their partners, and health care providers. In Phase I of this enabler and prior to initiation of the study, the researcher spent time at the larger MTF, observing prenatal care intake and provider visits and group prenatal care. The researcher also visited the military shopping and grocery facilities to make observations in natural settings. The primary task of the researcher was observing with active listening; taking in the whole situation was most important. During phase II, the researcher continued observing but also had limited participation in activities and events to move from distrusted stranger to trusted researcher. The researcher's observations of CNM-led prenatal care group sessions facilitated acceptance of the researcher by the group participants and provided the researcher an opportunity to observe interactions between pregnant African American women and others women in a care model that encouraged active participation. The researcher entered phase II prior to IRB

approval and once approved, continued with this phase through recruitment. The researcher entered phases III and IV during data collection. In phase III, the researcher actively participated and interacted with the women while continuing to observe what was naturally occurring with the women. The final phase, Phase IV, allowed the researcher to obtain and confirm essential information from the women (Wehbe-Alamah & McFarland, 2015a).

3.8 Ethical considerations

Ethical considerations were addressed in accordance with Duquesne University Institutional Review Board (IRB) (Appendix B), Madigan Army Medical Center IRB (Appendix C), and the Department of Defense Instruction 3216.02. Once IRB approvals were received, the study commenced. The gatekeeper and recruited participants were given a verbal and written explanation of the purpose and plans of the study, provisions for confidentiality, and the participant's right to withdraw from the study at any time. The gatekeeper is a valuable member of the organization who guides and acts as a liaison to potential participants and has the ability to grant or refuse entry into the community. They were also made aware that de-identified data would be shared with the Dissertation Committee. To maintain confidentiality, no identifying information was entered on the demographic forms and the participants were asked not to identify themselves when providing information during the interviews and focus groups. Participation in this study was voluntary and the participants were able to freely withdraw from the study at any time without fear of loss of health care or other repercussion. The participants signed a consent form (Appendix D), which was kept in a locked file in the researcher's home and separate from other study materials. The interviews were recorded using a digital voice recorder, transcribed verbatim, and de-identified. The transcribed data were stored on the researcher's password protected personal computer. As needed, de-identified data was shared

with the Dissertation Committee. All materials will be destroyed five years after the completion of the study.

In accordance with military human research policies, special considerations were taken during this study that involved active duty military personnel. Active duty participants freely elected to participate in the study without coercion or undue influence from superiors. Officers and those in the chain of command were not aware of the member's participation and were not present during recruitment. The commanding officers of the MTFs were made aware of this study and their approval letters were included in the IRB process (D. o. Defense, 2011). The researcher is an active duty member and her chain of command was also fully briefed on the purpose of the study (D. o. Defense, 2011). To avoid undue influence related to military rank, the researcher did not wear her military uniform during any phase of the study.

3.9 Data Collection

Once IRB approvals were granted, the researcher arranged a meeting with the Certified Nurse-Midwife gatekeeper to review the study in detail and set a date for recruitment to begin at the large MTF. Two days after the meeting, the researcher received permission to post recruitment flyers (see Appendix E) in designated areas throughout the MTF. Handouts (Appendix F) similar to the flyers were available for the gatekeeper to give to potential participants. Participants were invited to participate in the study by researcher and gatekeeper and in response to the recruitment flyers that were posted in key locations throughout the facility. These flyers and handouts contained a phone number that women interested in the study could use to contact the researcher for additional study information and to determine eligibility for the study. Women who met the eligibility criteria were invited to participate in the study. For focus group participants, the researcher obtained their first names and a contact number to call them

one week prior to remind them about the focus group. The first names and phone numbers were stored on the researcher's password protected computer. The researcher deleted the phone list after calling the participants to remind them of the focus group.

The ethnonursing data collection method was adapted to use only key participants for individual interviews and focus groups. The gatekeeper signed a volunteer confidentiality agreement (Appendix G) that described her role as solely a volunteer and not a researcher or participant, and asked the volunteer to keep the contents of the data collected confidential. Prior to beginning the interviews or focus groups, a verbal explanation of the consent form (Appendix H) was read aloud by the researcher and all questions were addressed prior to the participants signing the form. The participants were informed that this research was confidential and there would be no information used to identify their involvement. They signed the consent form, completed a demographic questionnaire (Appendix I), and were reminded that de-identified data would be shared with the Dissertation Committee. Focus group participants were also reminded that a disadvantage of focus groups is that confidentiality could not be guaranteed, but to assist in maintaining anonymity, they were asked to not disclose any information that was shared. A semi-structured interview guide (Appendix J) was used to collect data about the participant's perception of care during the prenatal period and field notes contributed data about what was occurring during the interview.

Recruitment for this study was initially only planned at the large Army MTF in the area; however, after four months of recruiting, there was only one participant. Three women made interview appointments within two to three days of initial contact, but they failed to show for their interview. Two women who met the inclusion criteria commented that they were used to receiving compensation for their participation; however, this study did not offer compensation

and they declined to participate. The researcher worked at the smaller Navy MTF in the area, but had chosen not to recruit at this location because she was well known by her rank and did not want to risk bias. After discussing the recruitment concerns with the dissertation chair and committee and the Chair of the IRB for Navy Medicine West (NMW), they concurred that the researcher was a "trusted friend" in this community and should seek IRB approval to recruit at the Navy MTF. On May 29, 2014, the Naval Medical Center San Diego/NMW IRB (Appendix K) granted permission for recruitment to begin at the Navy MTF. Duquesne University and Madigan Army Medical Center IRBs also approved the change in recruitment. The gatekeeper had once worked at the Navy MTF and was made aware of the addition of this site for recruitment.

The interviews and focus groups occurred in the MTFs because these locations were familiar to and agreed upon by the participants. Participants were interviewed for 60 to 90 minutes and the interviews were recorded using a digital voice recorder, transcribed verbatim, and de-identified. Twenty-one key participants participated in this study: 17 participated in individual interviews and 4 participated in two focus groups. Data saturation occurred at individual interview 15, followed by two additional individual interviews were conducted to confirm saturation. Three focus groups of five participants were planned, but no-shows resulted in one individual interview at one site and two groups of two women at the other site. The purpose of the focus group was discussed with them and they decided that they wanted to proceed with the focus groups despite the size. The two focus groups were then used to substantiate the categories, patterns, and themes that had become evident in the data from the individual interviews.

3.10 Data Analysis

The data were analyzed using Leininger's Four Phases of Ethnonursing Data Analysis (Appendix L). In the first phase, data were collected, described, and documented within the context of the domain of inquiry, purpose, and research questions. The focus was primarily *emic*, pertaining to the individual's (insider's) views and values about the phenomenon. In phase II, data were coded and classified within the context of the domain of inquiry. The data were coded for common phrases and relationships and 20 categories were identified. In phase III, the categories were evaluated and scrutinized to discover saturated ideas and recurrent patterns. Validity is addressed in this phase and defines as a process where knowledge is gained and the researcher understands "the true nature, essence, meaning, attributes, and characteristics" (p. 68) of the phenomenon of interest (Leininger, 1985). Nine patterns were identified. The final phase required synthesis of thought to abstract and present major themes, findings, and recommendations within the context of the Cultural Care Theory. Reliability is addressed in this phase, and Leininger (1985) described *reliability* as "identifying and documenting recurrent, accurate, and consistent or inconsistent features as themes, patterns, world views, or other phenomena confirmed in similar or difference contexts" (p. 69). The patterns were analyzed and three themes emerged.

Leininger (2002) identified six criteria to systematically evaluate and interpret ethnonursing research findings.

1. Credibility: refers to the accuracy, believability, and truths of evidence or information from the participants.

2. Confirmability: refers to the documented verbatim statements and first observational evidence from the participants who firmly and knowingly confirm and substantiate the data or findings.
3. Meaning-in-context: refers to understandable and meaningful findings that are known and held relevant to participants within their natural and familiar environmental contexts.
4. Recurrent patterning: refers to documented evidence of repeated patterns, themes, and acts over time reflecting consistency in patterned behaviors or lifeways.
5. Saturation: the exhaustive search from participants of data relevant to the domain of inquiry in which no new findings were forthcoming from participants.
6. Transferability: refers to whether the findings from a particular qualitative study can be transferred to or appropriately used in another similar culture(s) and within their context. (Leininger, 2002, p. 88; 2006, p. 24)

Leininger (2002) suggested that these criteria be studied prior to and during the study. According to Leininger and McFarland (2006), credibility, confirmability, and meaning-in-context must be used from the beginning to the end of the study with documentation (p. 24). Validity, reliability, and credibility of the themes were confirmed by comparing and contrasting the data collected during the focus group and by expert qualitative researchers.

The qualitative data analysis software package *Atlas.ti* 7 was used to code, process, and analyze the data obtained in the interviews and focus groups. *Atlas.ti* 7 is a data analysis software system primarily used for qualitative data analysis, but can be used to incorporate quantitative data into a document. It supported transcribing data directly into the created document. Accuracy and trustworthiness of all data was protected by transcription of the notes

and digital recordings immediately following the interview, by keeping reflexive journals, and by a multi-staged, iterative process with the dissertation committee, all qualitative experts.

3.11 Summary

This chapter discussed the ethnonursing method and the data collection methods that were used for this research study. The ethnonursing method allowed the researcher to learn from the participants "through their eyes, ears, and experiences and how they made sense out of situations and lifeways that were familiar to them" (Wehbe-Alamah & McFarland, 2015a, p. 42). The ethnonursing research data collection method was adapted to include individual interviews and focus groups with only key informants. The two data collection methods allowed the researcher to hear the voices of the women individually and collectively to gather in-depth information about the domain of inquiry. Review of the literature revealed that focus groups can be particularly useful when the domain of inquiry was best learned from those who actually experienced it and that key participants are the most knowledgeable about the cultural truths related to the domain of inquiry (Halcomb et al., 2007; Leininger, 2006; Liamputtong, 2011; Secor-Turner et al., 2010). Key informants told their stories from their actual lived experiences and were deemed the experts; therefore general informants were not included in the study. Ethnonursing allowed the researcher to discover the "care factors within familiar environments of people, and to focus on the interrelationships of care and culture to arrive at the goal of culturally congruent care services" (Leininger, 2006, p. 20).

3.12 This manuscript is prepared for publication

Adapting Leininger's Ethnonursing Research Data Collection Method Using Focus Groups and Individual Interviews

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Adapting Leininger's Ethnonursing Research Data Collection Method

Using Focus Groups and Individual Interviews

Abstract

In the ethnonursing research method, data collection traditionally occurs through the use of individual interviews with key and general informants. Key informants are the most knowledgeable about the domain of inquiry. When only key informants are used with focus groups and individual interviews, the depth of information discovered can illustrate the diversity and universality of the domain of inquiry. The purpose of this article is to explore adaptation of the ethnonursing data collection method in research using only key informants in individual interviews and focus groups to discover the experiences of culturally diverse populations, in this case, African American military women and female spouses. Recommendations for future research are offered.

Key words: African Americans, women, ethnonursing, focus groups

Introduction

The ethnonursing method was designed and created by Dr. Madeleine Leininger (1985) to work in concert with the theory of cultural care diversity and universality and to discover the lifeways of people that were influenced by their unique cultural experiences. Ethnonursing is a rigorous, systematic, and in-depth approach to generate concepts, theories, and hypotheses and to identify salient variables that have not been identified or that merit study (Leininger, 1985). It allows researchers to discover the "care factors within familiar environments of people and to focus on the interrelationships of care and culture to arrive at the goal of culturally congruent care services" (Leininger, 2006, p. 20). Ethnonursing is an appropriate method to use when there is no or very limited knowledge about a transcultural nursing phenomenon.

In ethnonursing research, data collection traditionally occurs through the use of individual interviews with key and general informants. Leininger (2006) defined key informants as those most knowledgeable about the domain of inquiry; in contrast, general informants only have general knowledge and are used to show how similar or different their ideas are to the key informants (Wehbe-Alamah & McFarland, 2015a). Key informants are the main source for checking the etic and emic relevance, meaning, accuracy, and dependability of data collected (Wehbe-Alamah & McFarland, 2015a). The depth of information discovered from key informants will illustrate the diversity and universality of the domain of inquiry. By using only key informants, the researcher may will discover not only what people think, but how and why they think as they do, and their understandings and priorities related to the domain of inquiry (Kitzinger, 1994). Additionally, offering focus groups as an option for data collection has potential in assessing sensitive issues from culturally diverse viewpoints (Lambert & Loiselle, 2008) and may be more congruent with the communication methods of some cultural groups.

Focus groups can "bring the researcher closer to the research topic through a close and intense encounter with key individuals" (Clarke, 1999) and allow the researcher to listen to the perspective of key stakeholders and learn from their experiences of the domain of inquiry (Halcomb et al., 2007). The purpose of this article is to explore adaptation of the ethnonursing data collection method in research using only key informants in individual interviews and focus groups to discover the experiences of culturally diverse populations, in this case, African American military women and female spouses.

Focus Groups

The focus group is a data collection method in which the opinions, values, and beliefs of participants are expressed collectively and individually and interactions between the participants are analyzed (Halcomb et al., 2007). Group interactions might accentuate member's similarities and differences and give rich information about the range of perspectives and experiences (Lambert & Loiselle, 2008). Focus groups have been used to draw information from members of diverse and vulnerable populations who are normally hard to reach, including disadvantaged and disenfranchised people (Liamputtong, 2011). When used in research with minority and multicultural groups, focus groups may provide a better understanding of consumer needs, culturally diverse perspectives, and people's experiences of a phenomenon so that culturally sensitive and appropriate interventions may be developed (Halcomb et al., 2007; Liamputtong, 2011; Secor-Turner et al., 2010).

African American Women

Gathering together and sharing family stories are inherent to African American culture. These time-honored practices and traditions allow African-Americans to reflect on and preserve the family's culture and history, share information that is important to future families, and

reaffirm an unwavering commitment to the family. Data collection methods such as group interviews, observation, and participant observations capture the holistic factors that impact their everyday lives (Secor-Turner et al., 2010). When used in research involving African American women, focus groups allow them to gather together and share information related to the domain of inquiry, and can bring forth detailed data about their experiences that may not be discovered with individual interviews alone.

Focus groups and individual interviews have been used in studies with African American women to explore a range of phenomena. Bruening et al. (2008) used focus groups and individual interviews to explore factors influencing African American women's participation in sports. Focus groups allowed the participants to be involved in the research process, established rapport between the interviewer and participants, and facilitated a free-flowing exchange of information (Bruening, 2004; Bruening et al., 2008). These data collection methods were also used to explore midlife African American women's risk taking and protective practices against HIV/AIDS (Mallory et al., 2009), experiences of African American women who provide care to family members living with HIV/AIDS (Tolliver, 2001), and the relationships between health, hunger, and food insecurities among African American women (Chilton & Booth, 2007). Harley et al. (2009) used individual interviews and focus groups to study African American women's initiation and continuation in a physical activity program. The authors disseminated preliminary findings from individual interviews to the focus groups and used member checking to ensure the findings represented the participant's experiences.

In studies exploring African American women and prenatal care, focus groups and individual interviews were used to examine the experiences of racial discrimination during prenatal care (Salm Ward et al., 2013). Focus groups were used as the sole data collection

method in research studies that examined factors affecting prenatal care attendance and preferences for prenatal care experiences among low-income African American women (Edmonds et al., 2015), provider characteristics that pregnant African American women considered important during prenatal care (Lori et al., 2011), and barriers to prenatal care among African American women of low socioeconomic status (Daniels et al., 2006). During the focus groups, participants were candid about their beliefs and thoughts about pregnancy, prenatal care, and factors that affected their actions toward the developing fetus (Daniels et al., 2006). The discussions were informative and comprehensive, gave voices to people who have been under-represented or marginalized, and allowed the participants to present their own views while interacting with and commenting on the experiences of others (Daniels et al., 2006; Salm Ward et al., 2013).

Data Collection Considerations

Focus groups are usually homogenous and consist of four to ten informants meeting one to three hours; however, smaller sized groups may be effective when discussing complex issues (Jayasekara, 2012). The location of the focus group should allow the participants to be relaxed and comfortable, and should be accessible to all involved (Clarke, 1999). The less structured the group, the greater the potential for the emergence of concerns that are relevant to the members (Stevens, 1996). Informants can initiate ideas without the fear of personal scrutiny that may occur in individual interviews because the ideas belong to the group rather than the individual (Stevens, 1996). During the group, informants build on the answers of others, often generating new and spontaneous ideas that the researcher did not think of before or during the interview (Holloway & Wheeler, 2009). The researcher must remain unobtrusive, encouraging the participants to freely express their points of view (Clarke, 1999; Lane et al., 2001).

Inherent in the focus group method is the potential for one member to dominate the conversation; however, the strengths of synergy and collective insight from the participants provide richer data that may not be collected from individual interviews (Stevens, 1996). Although group participants feel more free to engage in conversations about sensitive or social stigmatized events because they realize that they are not alone and that others have had similar experiences (Stevens, 1996), it is also possible the participants may give socially acceptable answers rather than honest answers about their experiences (Clarke, 1999).

Ethnonursing Method and Focus Groups

According to Leininger, research methods of the same paradigm may be combined if they fit the study purpose and the reason for combining the methods are made clear at the onset and with the domain of inquiry (Leininger, 1990; Wehbe-Alamah & McFarland, 2015a). The ethnonursing method has been combined with focus groups, phenomenology, ethnography, and life histories (Leininger, 2006; M. McFarland et al., 2012; Wehbe-Alamah & McFarland, 2015a). Focus groups can capture the social and cultural contexts that inform individuals' experiences and provide insight into the sources of complex behaviors and motivations (Secor-Turner et al., 2010). The homogeneity of the focus group may promote more open and honest discussions about the members' experiences than would conversation with individuals.

Focus groups and key informant interviews can "elicit information that is rich in context, meaning, and details" (Orlowski, 2014, p. 184), but the researcher must consider the rationale for using both methods. Lambert and Loiselle (2008) identified three rationales for using focus groups and individual interviews: (1) *pragmatic reasons*: offers informants the flexibility to choose the method in which they prefer to participate, (2) *compare or contrast (parallel use)*: each method is used with different groups of informants and the data from one method does not

influence the other; and (3) *data completeness and/or confirmation (integrated use)*: data completeness assumes that each method reveals complementary views of the phenomena of interest, while confirmation assumes that the findings of one method will corroborate the findings of the other method. The researcher will determine which data collection method to use first; however, focus groups may be used later to validate themes that emerge from individual interviews.

Application to Research

In an ethnonursing research study to discover how African American military women and female spouses perceived their experiences of care during the prenatal period, individual interviews and focus groups using only key informants were conducted for both pragmatic and confirmatory reasons. General informants would have only been able to give opinions about what they thought the women experienced; therefore, they were not used in this study. Purposive sampling allowed the researcher to restrict recruitment to those who experienced the care and could provide information-rich interviews to yield insight about the domain of inquiry. Inclusion criteria comprised the following: African American military women and female spouses who were 18 years old or older and who had a prenatal care experience in the past 15 years in a military or civilian facility in the U.S. or abroad. The researcher considered the key informants the most knowledgeable. Their experiences during pregnancy, included personal journeys influenced by acceptance of the pregnancy, adaptation to the physiologic and psychosocial changes of pregnancy, life circumstances, personal concerns, partners and other support persons, care providers, technology, and a host of other factors. In studies seeking to grasp personal experiences, hearing only the voices of those who are directly involved or impacted had the potential to bring out true emotions and deeper understandings of the

individual's perspective of the experiences when compared to the perceptions of others. These data collection methods were similar to how the women received prenatal care, either in the traditional, one-on-one setting or in a group with other women whose estimated due dates were within four weeks of each other.

Women who participated in the focus groups did not know each other, yet they openly shared their experiences as if they were acquaintances. They appeared at ease and comfortable, often turning towards each other to discuss the emotional, psychosocial, and financial impact of prenatal care on their overall experiences. No one's viewpoints were silenced and no one dominated the conversation or remained silent. They laughed during the discussions, especially when realizing that they shared similar experiences. They gave detailed descriptions of their experiences and validated and sympathized with each other's experiences. The interactions displayed during both focus groups were consistent with the literature. The focus group informants commiserated with each other and commented on each other's point of view (Stevens, 1996). The richness of the data was facilitated by the interpersonal communication between participants, which helped to clarify similarities and differences in expressed opinions (Kidd & Parshall, 2000). The focus group data enriched, validated, and gave credibility to the categories, patterns, and themes that had emerged during the individual interviews.

Conclusion

The ethnonursing research data collection method was adapted to include individual interviews and focus groups with only key informants, in a study to discover African American military women and family members' perceptions of care experienced during the prenatal period. The ethnonursing method allowed the researcher to learn from the informants "through their eyes, ears, and experiences and how they made sense out of situations and lifeways that were

familiar to them" (Wehbe-Alamah & McFarland, 2015a, p. 42). The two data collection methods allowed the researcher to hear the voices of the women individually and collectively to gather in-depth information about the domain of inquiry. Review of the literature revealed that focus groups can be particularly useful when the domain of inquiry is best learned from those who actually experienced it and that key informants are the most knowledgeable about the cultural truths related to the domain of inquiry (Halcomb et al., 2007; Leininger, 2006; Liamputtong, 2011; Secor-Turner et al., 2010). The key informants were considered the experts and told their stories from their lived experiences; therefore general informants were not included in the study. The rich depth of information discovered from the key informants during the individual interviews and focus groups illustrated the diversity and universality of their experiences. Future ethnonursing research studies using focus groups and interviews will provide an additional level of rich detail when only key informants are used. This data gathering technique also proved to be useful in exploring complex and sensitive topics in diverse populations who may be underrepresented in research.

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Chapter 4 This manuscript is prepared for publication.

Perceptions of Care During the Prenatal Period: An Ethnonursing Study of African American Childbearing Women in the Military Health System

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Perceptions of Care During the Prenatal Period: An Ethnonursing Study of African American Childbearing Women in the Military Health System

Abstract

Introduction: The military health system (MHS) offers prenatal care at no-cost, but African-American women eligible for prenatal care still have low/no/late utilization. No studies have sought to understand factors that influence African American women's use of early and continuous prenatal care or their perceptions of the care they received in the military health care system. The purpose of this research was to understand how African American women in the MHS perceived their care during the prenatal period. **Methodology:** An ethnonursing study was conducted in two military treatment facilities. The sample comprised 21 participants. **Results:** Leininger's Four Phases of Ethnonursing Data Analysis revealed three themes related to African American women's perceptions of care experienced during the prenatal period. **Discussion:** Women experienced positive prenatal care experiences when they had continuity of care and a circle of support. Recommendations for care that is culturally congruent and future studies are offered.

Key words: African Americans, women, military, ethnonursing, prenatal care, focus groups

Introduction

Prenatal care (PNC) services are offered at no cost to all active duty military women and female family members under Tricare Prime, a managed care option providing comprehensive health coverage. Despite this fact, African American women continue to have low/no/late PNC utilization. A 2005 Department of Defense survey reported that military African American women were slightly less likely to initiate PNC in the first trimester when compared to women of other racial groups (Bray et al., 2006). Studies evaluating PNC utilization among military women are few and those that include all military women are outdated. No studies have sought to understand factors that influence military African American women toward early and continuous PNC or their perceptions of the care they received. The purpose of this ethnonursing study was to understand how African American childbearing women in the Military Health System (MHS) perceived their care during the prenatal period. In this study, African American women included active duty service women and female spouses of active duty service men. The cultural care knowledge obtained through this study lays the foundation for nurses and other health care professionals to develop and promote PNC. The findings also support the development of policies that are culturally congruent and consistent with the needs and desires considered important to promote positive experiences of care for African American women.

Review of Literature

Early initiation of PNC, preferably in the first trimester, increases the potential for health concerns to be identified and provides an opportunity for women to receive lifestyle and health behavior recommendations and referrals to additional resources if needed (P. Johnson et al., 2010). The frequency and regularity of PNC visits should be sufficient to enable health care providers to assess maternal and fetal well being, provide on-going, timely, and relevant

education, complete recommended studies and review results, and detect complications and institute indicated interventions (A. A. P. Committee on Fetus and Newborn & A. C. O. G. Committee on Obstetric Practice, 2012).

Adequate and inadequate PNC users shared motivators to have healthy babies, learn better health habits, and understand how to improve their health (A. Johnson et al., 2007). Women were also motivated to seek PNC by friends, family, and their desire to increase their social support to minimize depression, ambivalence, and isolation (Edmonds et al., 2015). Partner involvement influenced PNC attendance, as women made "deals" that they would go for care if their partners attended PNC visits; otherwise, they would wait until their partners could attend (Daniels et al., 2006). For African American women, PNC was considered important, it was just not always considered as important as their other daily life concerns (Daniels et al., 2006).

Providers who listened, took the time to address all of their questions and concerns, communicated clearly, and were nonjudgmental and respectful promoted quality patient-provider interactions (Lori et al., 2011; Sword et al., 2012). Women wanted correct health information and acknowledgement for what they knew about their health, and they preferred an active role that was client-centered and allowed them to control their situations. Continuity of care with a provider enabled women to establish a trusting relationship and optimize the visit because the provider knew them (Lori et al., 2011). Through repeated interactions with the same provider, the interpersonal trust that developed between patients and providers allowed patients to evaluate the trustworthiness of the provider and to share health concerns and receive recommendations to improve health (Gamble, 2006; Peters et al., 2014).

To date, there has been only one military study that investigated racial disparities in outcomes in military and civilian births. Barfield et al. (1996) retrospectively analyzed 2,222,044 records over five years. The study included 79,154 records of women who received care in a military hospital, of which 12,807 records were from African American women. The researchers found that 75.1% of African American women began PNC in the first trimester compared to 79.3% white women. The percentage of black and white women who began care in the third trimester or had no PNC at all was significantly larger than in the civilian population (Barfield et al., 1996). This study demonstrated that despite having access to free PNC, the problem of no/late initiation of care also existed among African American women in the MHS.

African American women understood that seeking PNC and taking care of themselves were important for their health and fetal growth and development; however, there were barriers that delayed entry into care services and prevented continuous care. There is a scarcity of research on prenatal care among African American women in the MHS. This study was designed to give them a voice to promote the discovery of knowledge that may fill the gap regarding how culture can impact health care behavior.

Guiding Theoretical Framework

The theory of culture care diversity and universality guided this study and provided the theoretical framework for understanding African American military women and female spouses' experiences of care during the prenatal period. The purpose of the theory is to "discover, document, know, and explain the interdependence of care and culture phenomena with differences and similarities between and among cultures" (Marilyn McFarland & Wehbe-Alamah, 2015, pp. 5-6). The theory focuses on the belief that culturally diverse people can inform and influence professionals to provide them the kind of care they desire or need.

Research Questions

1. In the MHS, what are African American women's perceptions of care experienced during the prenatal period? 2. In the MHS, how do worldviews and cultural/societal factors influence African American women's experiences of care during the prenatal period? 3. In the MHS, what ways do nursing practices impact or impede African American women's experiences of cultural care in the MHS during the prenatal period?

Method

Leininger's ethnonursing method was used to elicit meaningful and culturally rich data for this study. Ethnonursing is a rigorous, systematic, and in-depth approach for studying multiple cultures and care factors within the people's own world, focusing on the interrelationships of care and culture to achieve the goal of providing culturally congruent care (Wehbe-Alamah & McFarland, 2015a). Ethnonursing research enablers were guides used by the researcher to conduct the study and explicate data in an organized manner and to gain culture care knowledge in natural ways (Wehbe-Alamah & McFarland, 2015b). Three enablers were used in this study: (a) sunrise enabler, a guide that identified factors that needed to be systematically studied with the theory of cultural care and was used to explore comprehensive and multiple influences on care and culture (Wehbe-Alamah & McFarland, 2015b); (b) observation-participation-reflection enabler, a reflection guide used during observations of African American women at various locations on the military bases and during group prenatal care sessions; and (c) the stranger-to-trusted friend (STF) enabler, a guide used to "enter the world of the participants to learn about care meaning and practices" (Leininger, 2006, pp. 26-27).

Prior to beginning the study, the researcher (T.H.S.), who is an African American military Certified Nurse-Midwife (CNM), recognized the importance of being aware of

preconceived notions about PNC and group interactions that could hinder discovery of new information. The researcher used the care concepts *unknowing*, *reflection*, *presence*, and *knowing* to remain observant of what was actively and passively occurring (Plowden & Wenger, 2001). In *unknowing*, the researcher sought exposure to new experiences. The goal was to allow the participants to "teach me" about them. *Reflection* sought to discover "what is going on here?" To have *presence* was to be in the moment and connect to the environment without being judgmental. In *knowing*, the researcher acknowledged the real environment and gained an understanding of the participant's lifeways.

Setting and Participants

A University and the Department of Defense institutional review boards approved this study at two military treatment facilities (MTF). Twenty-one key participants participated in this study: 17 participated in individual interviews and 4 participated in two focus groups. The interviews and focus groups occurred in the MTFs because these locations were familiar to and agreed upon by the participants. To avoid undue influence related to military rank, the researcher did not wear her military uniform during any phase of the study. Purposive and snowball sampling were used in recruitment. Purposive sampling allowed the researcher to restrict recruitment to those who experienced the care (Scott, Zoucha, Lauderdale, & Nickerson, 2017). Women who met the following inclusion criteria were invited to participate in the study: ages 18 to 40 years not currently pregnant and with prior prenatal experience in the last 15 years; on active duty in the military or the female spouse of an active duty service member; identified self as African American; had PNC in a military or civilian facility in the U.S. or abroad; willing to participate in the study; and, agreed to participate in one interview and/or a focus group.

Data Collection

The ethnonursing data collection method was adapted to use only key participants for individual interviews and focus groups. Key participants are those most knowledgeable about the domain of inquiry (Wehbe-Alamah & McFarland, 2015a) and could tell their stories from their lived experiences; in contrast, general participants had general knowledge and would have only been able to give opinions about what they thought the women experienced. Offering focus groups has potential in assessing sensitive issues from culturally diverse viewpoints (Lambert & Loiselle, 2008). A semi-structured interview guide was used to collect data, table 1.

Table 1. Semi-Structured Interview Guide

1. Tell me about the care you experienced in the military health system during your pregnancy.
2. Tell me how your family and friends supported you during your pregnancy.
3. Please tell me what the terms "health" and "healthy pregnancy" means to you.
4. Please describe how your cultural beliefs, practices, and values influenced the way you cared for yourself during your pregnancy.
5. Describe the ways you obtained prenatal information during your pregnancy.
6. How did the cost of health care influence your prenatal care decisions?
7. How did health care professionals impact or support your prenatal care decisions?
8. How did the military impact or support your care experience?

Field notes contributed data about what was occurring during the interview. Prior to the interviews, the participants completed a demographic questionnaire and were made aware that de-identified data would be shared with the Dissertation Committee. Focus group participants were reminded that a disadvantage of focus groups is that confidentiality could not be guaranteed, but to assist in maintaining anonymity, they were asked to not disclose any information that was shared. Participants were interviewed for 60 to 90 minutes. The interviews were recorded using a digital voice recorder, transcribed verbatim, and de-identified. Data saturation occurred at individual interview 15, followed by two additional individual interviews

were conducted to confirm saturation. Two focus groups were then used to substantiate the categories, patterns, and themes that had become evident in the data.

Data Analysis

The data were analyzed using Leininger's Four Phases of Ethnonursing Data Analysis. In the first phase, data were collected, described, and documented within the context of the domain of inquiry, purpose, and research questions. In phase II, data were coded and classified within the context of the domain of inquiry. The data were coded for common phrases and relationships and 20 categories were identified. In phase III, the categories were evaluated and scrutinized to discover saturated ideas and recurrent patterns. Nine patterns were identified. The final phase required synthesis of thought to abstract and present major themes, findings, and recommendations within the context of the Cultural Care Theory. The patterns were analyzed and three themes emerged. Data analysis was a multi-staged, iterative process with the dissertation committee, all qualitative experts. Table 2 presents the analysis of the data.

Table 2. Data Analysis using Leininger's Four Phases of Ethnonursing Analysis

Phase II **Categories (n=20)**	**Phase III** **Patterns (n=9)**	**Phase IV** **Themes (n=3)**
Prenatal care definition Prenatal care use	A pattern of prenatal care that promotes healthy life habits and provides informational support that motivates women to seek care	African American military women and female spouses have positive prenatal care experiences when psychosocial and informational support are given by trusted and familiar sources
Experience of care Continuity of care Potential barriers Trust	A pattern of trust in the provider and continuity of care are essential to positive care experiences	
Expectations from nurses Nursing involvement	A pattern that nurses are viewed as informers who are available in person or by phone to provide support	
Staying well Money for baby	A pattern of financial resources as important to taking care of self and	Healthcare, financial, prenatal, and educational

and food	preparing for baby	resources are valued components for taking care of self and preparing for baby
Healthcare benefits	A pattern of military healthcare and prenatal resources that may not be available in the civilian healthcare system	
Internet and apps Resources	A pattern of care information that is accessible and enriched through traditional and web-based resources	
Family Beliefs and traditions Wives tales	A pattern of care beliefs and practices that are influenced by family, friends, and what would occur if they were at home with family	Emotional and instrumental support from expectant fathers, family, friends, and the military reinforced prenatal care beliefs, decreased maternal stress, and promoted expectant fathers' participation in prenatal care
Family involvement Friends helped Partner/spouse involvement	A pattern of support from expectant fathers, family, and friends provided assurance and decreased stress	
Military partner/spouse Prenatal care and military	A pattern of military leadership understanding the needs of pregnant service women and encouraging expectant fathers' participation in prenatal care	

Validity, reliability, and credibility of the themes were confirmed by comparing and contrasting the data collected during the focus group and by expert qualitative researchers. Leininger (2002) also identified six criteria to systematically evaluate and interpret ethnonursing research findings. Table 3 presents the six criteria. *Credibility*, *confirmability*, and *meaning-in-context* must be used from the beginning to the end of the study (Leininger, 2006).

Table 3. Six Criteria to Evaluate and Interpret Ethnonursing Research Findings

Criteria	Definition	Application in research study
Credibility	Refers to the accuracy, believability, and truths of evidence or information from the participants.	The STF enabler was used to gain entry into the participants' world. Careful selection of the participants conducted through purposive and snowball sampling. Key participants were used because they were the best source of their experiences.
Confirmability	Refers to the documented verbatim statements and first observational evidence from the participants who firmly and knowingly confirm and substantiate the data or findings.	Focus groups participants were also key participants who were the most knowledgeable about their care experiences. Data from the focus groups were used to substantiate the data discovered during the individual interviews.
Meaning-in-context	Refers to understandable and meaningful findings that are known and held relevant to participants within their natural and familiar environmental contexts.	The interpretations and meanings placed on the experiences of prenatal care by all of the key participants provided the meaning-in-context for this study.
Recurrent patterning	Refers to documented evidence of repeated patterns, themes, and acts over time reflecting consistency in patterned behaviors or lifeways.	The patterns and themes that developed during the individual interviews were confirmed with the focus group interviews.
Saturation	The exhaustive search from participants of data relevant to the domain of inquiry in which no new findings were forthcoming from participants	The researcher realized saturation at individual interview #15 and conducted two additional individual interviews to confirm saturation. Two focus groups were then used to substantiate the categories, patterns, and themes that had developed.
Transferability	Refers to whether the findings from a particular qualitative study can be transferred to or appropriately used in another similar culture(s) and within their context.	The findings may not be transferable to similar ethnic cultures, but they may be transferable within the military culture. The participants were recruited from two military treatment facilities in the same geographic area; however, the women experienced care at various military and civilian treatment facilities and gave their perspectives based on that care.

Findings

Twenty-one African American women between the ages of 20 to 34 years participated in this study (Table 4). Seventeen key participants participated in individual interviews and/or four participated in focus groups. Thirteen (62%) were active duty service women.

Table 4. Participant Demographics (N=21)

Characteristic	**n (%)**
Age, mean SD, y (range 20-34)	24 (3.9)
Family status, n (%)	
Single	5 (24)
Married	15 (71)
Divorced	1 (5)
Military status	
Active duty	13 (62)
Spouse	8 (38)
U. S. Military Branch	
Army	2 (10)
Navy	19 (90)
Number of children	
1	13 (62)
2	7 (33)
3	1 (5)
Prenatal Care (PNC)	
Individual PNC	12 (57)
Active duty	7
Spouse	5
Group PNC	9 (43)
Active duty	6
Spouse	3
Prenatal Care visits (participant reported)	
</= 5	1 (5)
6 - 9	13 (62)
10 or more	7 (33)

After critical examination of the patterns and categories identified in phases II and II, three themes representing African American women's perceptions of PNC emerged. Theme 1: African American military women in the MHS have positive PNC experiences when psychosocial and informational support is given by trusted and familiar sources. Theme 2: Health care, financial, prenatal, and educational resources are valued components for taking care of self and preparing for baby. Theme 3: Emotional and instrumental support from expectant fathers, family, friends, and the military reinforced PNC beliefs, decreased maternal stress, and promoted expectant fathers' participation in PNC. The data collected during the focus groups confirmed the themes that emerged during the individual interviews.

***Theme 1*: African American women in the MHS have positive prenatal care experiences when psychosocial and informational support are given by trusted and familiar sources**

Prenatal care supported the participant's desires to maintain their health to support fetal growth and development and was needed to help them identify self or fetal concerns that required immediate action.

> Prenatal care is making sure that your baby is okay…making sure that everything's okay. You get your medicine. You get your blood checked...I think no one should ever skip out on prenatal care. You should always know or want to know what's the next step for you and your baby.

There was consensus among the participants regarding the need to come for care early and often, and nurses were usually the first health care professionals they interacted with. Nurses were the primary source for health and nutrition information and the liaison to other resources, including social work and military family readiness groups. The support and information they offered complemented the care the participants received from the PNC provider.

Continuity of care enhanced the participant's care experience and facilitated a trusting patient-provider relationship where prenatal concerns and personal stressors could be shared and attended to by the provider. Eighty-two percent of the participants reported they trusted their provider and 67% experienced continuity of care during the prenatal period.

> When you see someone different every time…they don't connect with you, but with continuity, they sit down and they talk to you and they remember what you said the last time you were in, and you feel like they care about you and they care about your pregnancy.

Group prenatal care (GPNC) by one PNC provider and a nurse facilitator offered continuity of care and incorporated prenatal education and support into a two-hour PNC session. Fifty-two percent of the participants participated in GPNC and reported it fostered friendships, provided support, and gave them an opportunity to discuss their pregnancy concerns with other women. One participant reported, "it made that abnormal feeling of pregnancy normal."

***Theme 2*: Health care, financial, prenatal, and educational resources are valued components for taking care of self and preparing for baby**

> There was (sic) a lot of things I could see myself not having been able to do if I didn't have the health care that I did…I wouldn't have been able to come to Centering classes and probably would have picked and choosed (sic) appointments, just the most important ones.

All of the participants discussed the benefits of military health care, including that it was free and provided full health coverage, was easily accessible, and offered free resources that may not be available in the civilian health care system. Although none of the participants determined that money was needed to obtain care, 71% of the participants reported that money was needed to prepare for the baby and to purchase basic necessities, including food, shelter, and gas. Several of the participants attended childbirth education and lactation classes. Budgeting classes

taught them how to better manage their finances and helped them understand the financial impact of childrearing.

The participants used the Internet to supplement their prenatal health knowledge between care visits and the information received from health care professionals. Seventy-six percent of the participants used Internet sites and apps, social media, and online support groups to enhance their understanding of fetal growth and development and the physiologic changes of pregnancy.

> My Baby (app) … gave me things I could look out for…It reminded me to walk…to eat healthy, and it told me how my body was changing. How the baby was growing, like what size he would probably be each month.

They preferred pregnancy apps to books and magazine because the apps were mobile and readily accessible on their smartphones and tablets and could be personalized to provide up-to-date information about pregnancy, health and wellness, and fetal growth.

Self-care during the prenatal period included healthy eating, exercising, avoiding undue stress, and resting. Two participants ate cultural foods during the prenatal period because these foods reminded them of being at home with family. Sixty-seven percent (67%) of the participants did not practice family traditions while they were separated from their family; however, they did resume these traditions during visits from or to family, especially female family members. Family beliefs and traditions influenced timing of pregnancy disclosure (wait until after second trimester), acceptance of genetic screening tests, and avoidance of medications other than prenatal vitamins.

Theme 3: **Emotional and instrumental support from expectant fathers, family, friends, and the military reinforced prenatal care beliefs, decreased maternal stress, and promoted expectant fathers' participation in prenatal care**

> It was really different…not to be able to lay (sic) up under my momma and just tell her how things were going. And, it was really different delivering because… before, my parents were there…this time there were really no visitors, it was just me and my husband.

Family support was highly valued by the participants; however, only four participants had family present to provide the physical, social, and emotional support they felt they needed during the prenatal period. Family who were away offered general pregnancy advice, but this was perceived by participants to be the same as them being present. The participants felt strongly that the presence of female family members would have decreased the stress of being pregnant. A participant stated, "Family would have helped a lot...with everything being scary and new. 'Cause I think it's just the difference between having friends and having family there…I would have had lot less stressful moments." When family was not present, the participants expected the expectant fathers to provide support. Expectant fathers were described as present, emotionally involved, and engaged in learning more about the pregnancy and fatherhood. According to one participant, "He was my main support system at home since we both came out here and had no family or nothing like that…we did different exercises…we got out and walked every day or every other day." Unfortunately, for some participants, the lack of support contributed to feelings of loneliness, depression, and increased stress. Women with prior PNC experience, pregnant co-workers, and female friends gave advice and encouragement, offered emotional support, and filled the gap when family and expectant fathers were not available. Having a circle

of support promoted the participants' understanding of the physical and psychological changes of pregnancy, adjustment to motherhood, and accommodation of military life and motherhood.

Active duty women considered their military leaders supportive if they recognized pregnancy as a normal part of a woman's life, demonstrated positive attitudes towards pregnant service women, and understood the health care needs of pregnant women. The majority of the participants reported their leaders supported their PNC visits and classes. All of the participants had military husbands or partners and they reported that expectant fathers who received leadership support were more involved and demonstrated a greater understanding of their role during the prenatal period.

> My husband was present at I'd say 99% of my prenatal appointments…I think it helped too that all his superior officers were fathers…that made them more understanding versus somebody who had no kids and had no understanding of the process of how a baby gets here.

Discussion

The findings of this study revealed that African American women in the MHS have positive PNC experiences when they have continuity of care with health care professionals with whom they could discuss sensitive matters and stressors that were impacting their lives. Consistent with the literature, the participants confirmed that continuity of care promoted trust in the provider and facilitated positive patient-provider relationships that allowed them to be actively involved in their care and the decision-making process (Gamble, 2006; Peters et al., 2014). Group prenatal care provided participants continuity of care with a provider-nurse team and maternal and fetal health and well-being information through discussions with others. It also offered social support which decreased stress, anxiety, and depression, demonstrated similarities among the women which helped them become more comfortable and connected, and helped

them realize they were not alone in what they were experiencing during the pregnancy (Kennedy et al., 2009; Novick et al., 2011). The participants agreed that nurses contributed to their care by being nonjudgmental and supportive, and by offering a variety of information to promote health, wellness, and infant care and to access community and military resources that could assist them with adjusting to motherhood and the military lifestyle. The participants also used web-based resources to supplement PNC education between visits.

In the MHS, African American women's PNC experiences were influenced by the military lifestyle. Participants who developed a circle of support were better able to adapt to military life and the changes of pregnancy. Many active duty women were relocated from military duties/jobs that posed harm to them and their growing fetus'. The challenge of balancing the demands of military life and advancing their careers while away from their primary job/duty imposed significant stress on active duty women. The active duty women wanted military leaders to understand the demands of pregnancy on service women and support them as they engaged in PNC. A common stressor for all of the participants was the potential for expectant fathers to be away on deployment for some or all of the prenatal period or attending to military readiness duties, which often took priority over PNC visits. The likelihood of expectant fathers being away during a pregnancy is lessened when the pregnancy is planned around his operational rotations, but this study did not focus on expectant father involvement during planned pregnancies or inquire whether the pregnancy was planned. When expectant fathers were available, African American women strongly desired military leaders to support their involvement in PNC visits and childbirth and parenting classes.

Implications for Practice and Research

Leininger identified three modes of cultural care to guide nurses' decisions and actions for providing safe, congruent, and beneficial care: cultural care preservation and/or maintenance; cultural care accommodation and/or negotiation; and, cultural care repatterning and/or restructuring (Marilyn McFarland & Wehbe-Alamah, 2015). This study offers recommendations to help health care professionals understand the care practices African American women should retain, accommodations that could foster culturally congruent care, and modifications that may improve health (Table 5).

Table 5. Cultural Care Modes of Decisions and Actions

Cultural Care Preservation and/or Maintenance: acts or decisions that help cultures preserve or maintain beneficial care practices, beliefs, and values

- Nurses must recognize the needs and desires of women during the prenatal period and factors that may influence initiation and continuation of care.
- Healthcare professionals must recognize and preserve health-promoting care practices of the mother by ensuring the she has the information needed for self-care.
- Healthcare professionals must recognize the importance of female family members' and friends' involvement in self-care practices and preserve these bonds.
- Healthcare professionals must recognize that the women's circle of support influences her self-care practices and is a source of empowerment and strength.
- Healthcare providers must promote continuity of care to facilitate trusting patient-provider interactions and positive care experiences.
- Healthcare professionals must preserve information-sharing opportunities to enhance women's understanding of the psychological and physical changes of pregnancy.
- Healthcare professionals must recognize the utility of available resources including mobile apps and the internet, to fill the gaps between appointments and further build women's knowledge related to pregnancy, fetal development, and parenting responsibilities.

Cultural Care Accommodation and/or Negotiation: acts or decisions that help cultures adapt to or negotiate with others for culturally congruent, and safe care

- Healthcare providers may need to negotiate with command leaders for expectant fathers to attend prenatal care visits.
- Healthcare providers may need to make accommodations to promote partner involvement in prenatal care when they are present at the care visit.
- Healthcare providers may need to facilitate an environment where care concerns are addressed in an unhurried and attentive manner.
- Healthcare providers may need to accommodate more frequent visits to evaluate the mental health and wellbeing of women who do not have expectant father or family involvement or an identified circle of support.

Cultural Care Repatterning and/or Reconstructing: acts or decisions that would help people reorder, changes, modify, or restructure their lifeways

- Participants should utilize group prenatal care to achieve continuity of care and social support from women experiencing similar concerns during the prenatal period.
- Participants who are living away from their nuclear family should establish a circle of support including expectant fathers, friends, and co-workers to promote better adaptation of the changes of pregnancy and accommodation of the military culture during pregnancy.
- Healthcare providers should consider offering evening appointment hours to facilitate/promote attendance by expectant fathers who work during the day.
- Healthcare providers can implement specific apps or internet-based education into the pregnancy care plan to build women's self-care and prenatal care knowledge base.
- Healthcare professionals can re-educate command leaders on the military services' pregnancy policies and resources that are available.

The American Association of Colleges of Nursing asserts that nurses should generate data-based research to improve culturally competent patient care (AACN, 2009). The military is a microcosm of the larger society; an entity with numerous subcultures with their own traditions, beliefs, and practices that may influence women's care seeking behaviors. The findings of this study contribute new data to inform health care professionals on the importance of transcultural care and research in the military. They are exposed to many different cultures and have to be sensitive to the unique needs of the women they serve. The findings of this study can be compared to that conducted with civilian African American women, but may also be applicable to all cultural groups in the military. Future research including military women and female spouses of different ethnic groups is needed to explore the diversity and universality of

perception's of care experienced during the prenatal period and to inform nurses and health care providers on how to deliver care that is culturally consistent and meaningful to the patient.

Having a circle of support fostered the women's ability to adapt to the various stressors that were impacting their lives. Health care professionals providing initial prenatal screening visits must recognize the importance of support systems and refer African American women with no or limited support to appropriate resources for assistance. Women are screened for postpartum depression between the second and third trimesters and this is an optimal time to re-evaluate the support systems that will be in place at time of delivery. Military duties may prevent expectant fathers from attending all PNC visits, but involving them when they are present and encouraging them to participate in other available resources related to maternal and infant care may promote greater involvement during the prenatal period. This study found that African American women reported loneliness, depression, and increased stress when expectant fathers were not present or involved. Future studies should explore military expectant father's perspectives of involvement and health outcomes during planned and unplanned pregnancy and health care professionals' perspectives of care given during the prenatal period. More than half of the participants used web-based resources/apps to expand their PNC knowledge. For some, the decision to seek care was often motivated by the information found on pregnancy apps or health-related Internet sites. This information confirmed their knowledge and perceptions about their concerns and normalized their experiences (Lagan, Sinclair, & Kernohan, 2011; Song, West, Lundy, & Dahmen, 2012). As the use of these resources become the norm, health care professionals will still be expected to provide information, but also refer women to reliable sites where they can further educate themselves and become more informed consumers. The impacts of these

resources on patient care seeking and health care professional's care giving during the prenatal period warrant further study.

Limitations

The findings of this research may be limited on the basis of generalizability because these qualitative findings were collected from women associated with two military installations; however, the women delivered at various military and civilian facilities and gave their perspectives based on that care. The findings were similar regardless of where they experienced PNC. The women in this study engaged in rich descriptions casually and readily shared information. The researcher (T.H.S) adapted the ethnonursing data collection method to include individual interview and focus groups with key participants and contends that women were the experts of their experiences and could provide the richest data; therefore general participants were not included in this study (Scott et al., 2017).

Conclusion

The purpose of this ethnonursing study was to understand how African American childbearing women in the Military Health System (MHS) perceived their care during the prenatal period, the factors that influenced their care experiences, and how nursing practices contributed to their cultural care. Results of this study contribute knowledge to fill the gap regarding perceptions of care and generate care actions that health care professionals can take to deliver care that is meaningful and culturally congruent. Health professionals in the MHS can use these finding to promote education and practices to improve health behaviors and outcomes and to conduct future studies to understand military culture related to maternal care and expectant father involvement during the prenatal period.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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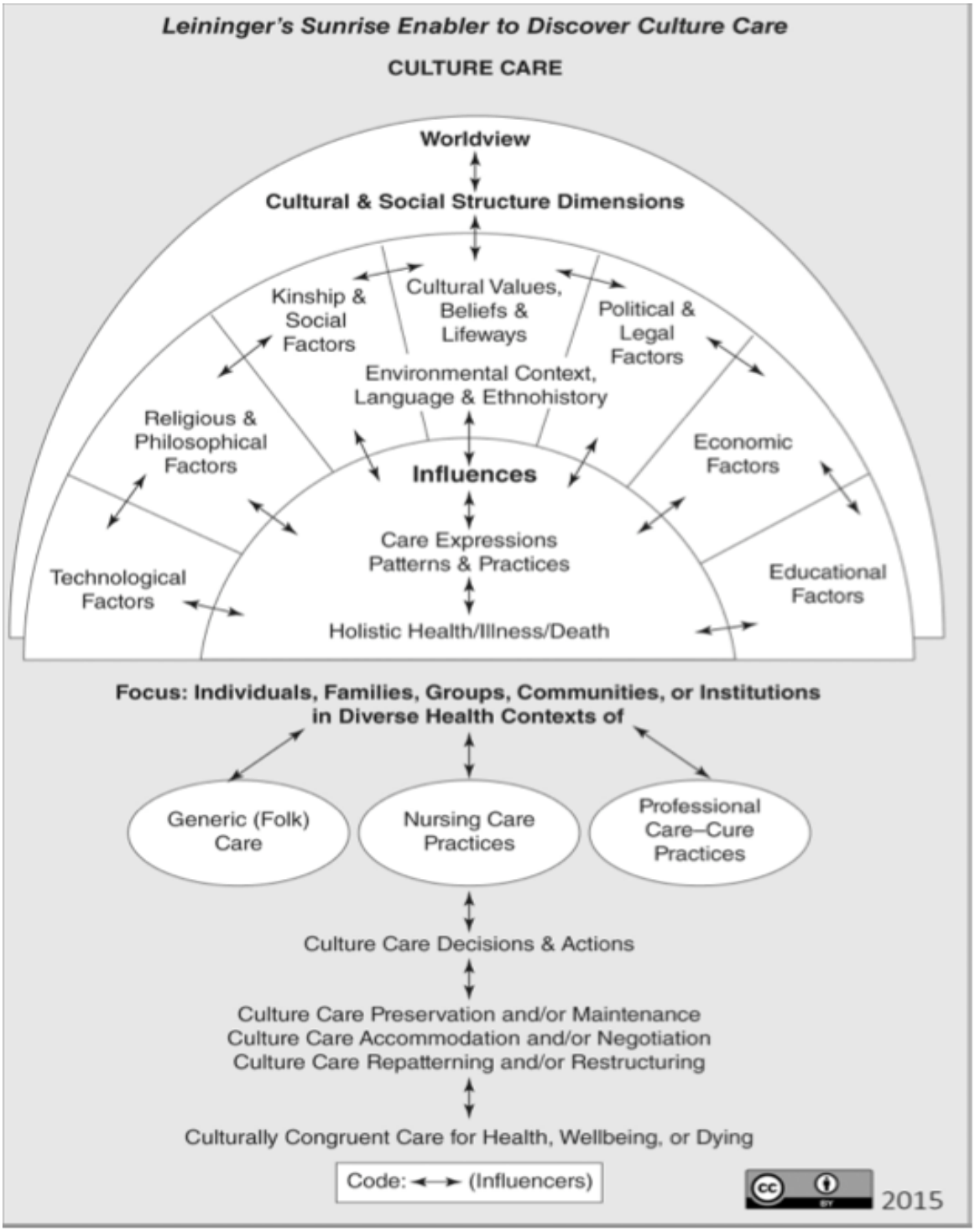
Appendix A



Wehbe-Alamah, H., & McFarland, M. (2015b). Leininger's enablers for use with the ethnonursing research method. In M. McFarland & H. Wehbe-Alamah (Eds.), *Leininger's culture care diversity and universality: A worldwide nursing theory* (3rd ed., pp. 73-100). Burlington, MA: Jones & Bartlett Learning.

Appendix B

DUQUESNE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
310 AMINISTRATION BUILDING ♦ PITTSBURGH PA 15282-0202

Dr. Linda M. Goodfellow
Chair, Institutional Review Board
Phone (412) 396-6326 Fax (412) 396-5176
e-mail: goodfellow@duq.edu

August 16, 2013

Re: Protocol # 13-108: African American Military Women and Family Members' Experiences of Care during the Prenatal Period_

Dr. Richard Zoucha
School of Nursing
Duquesne University
Pittsburgh PA 15282

Dear Dr. Zoucha :

Thank you for submitting the research proposal of your student, Thecly Scott.

Based upon the recommendation of IRB member, Dr. Denise Lucas, and my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an **expedited** basis under 45CFR46.110.

The consent form is attached stamped with IRB approval and expiration date. Ms. Scott should use the stamped form as original for copies that she distributes or displays.

The approval must be renewed in one year as part of the IRB's continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if the consent form is still in use in one year, it will need to be renewed by our office. In correspondence please refer to the protocol number shown after the title above.

If you and Ms. Scott propose any changes in procedure or consent process, you must inform the IRB of those changes and wait for approval before they are implemented. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. You and Ms. Scott should retain a copy of research records, other than those destroyed for confidentiality, over a period of five years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.

If you have any questions, feel free to contact me at any time.

Best,

Linda M. Goodfellow, PhD, RN

Linda M. Goodfellow, PhD, RN

C: Dr. Zoucha
Thecly Scott
Denise Lucas
IRB Records

Appendix C

DEPARTMENT OF THE ARMY
MADIGAN ARMY MEDICAL CENTER
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF

MCHJ-CLI

DATE: 07 January 2014

TO: Mary Paul Backman, MC
FROM: Chair, Madigan Army Medical Center IRB

SUBJECT: Initial Approval of Research Protocol
STUDY TITLE: Doctoral Dissertation Research Study: African American Military Women and Female Spouses' Experiences of Care during the Prenatal Period
REFERENCE #: 214022
IRBNet #: 390004-1
SUBMISSION TYPE: Local

ACTION: APPROVED
APPROVAL DATE 07 January 2014
EXPIRATION DATE: 06 January 2015
REVIEW TYPE: Expedited

1. Congratulations! Your protocol (version date 06 December 2013), including all accompanying study documents was found to have scientific merit and IAW 32 CFR 219.110(b)(1), categories 6 & 7 is approved as a minimal risk human use protocol by expedited procedures on 07 January 2014 for a period of one year, expiration date 06 January 2015.

2. You are authorized to consent and interview not more than 48 African American women ages 18-40 that are either active duty military members or are the spouse of an active duty military member, have received prior prenatal care and meet the study inclusion criteria.

3. A consent form (stamped/dated 07 January 2014 expiration date 06 January 2015) was approved IAW 32 CFR 219.116 and 45 CFR 164.512, respectively. **The approved stamped consent form must be duplicated and used for enrolling subjects.**

4. This research study does not meet the confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA) as PHI will not be used or disclosed as part of this research.

5. Please note that the Chair's approval of this study will be reported to the IRB at the next convened meeting on 08 January 2014.

6. A copy of the final approved research protocol documents will be posted on IRBNet for your access. You may begin work on the project at Madigan upon receipt of this letter.

7. This approval is only for one year from the time of approval. As part of your continuing review and re-approval and in order to keep your research ongoing, you are **required** to submit a continuing review report by December 2014. Failure to do so may result in a lapse of approval and a halt to your research project.

8. There is no funding associated with this study.

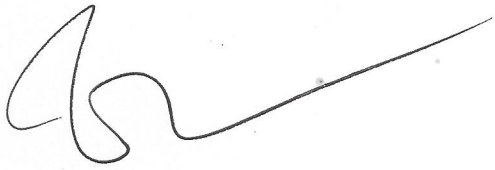
9. As the Principal Investigator (PI), you are required by Federal, DoD, Army and Madigan Army Medical Center regulations and policies, to submit the following in a timely fashion to the Institutional Review Board, if applicable:

(a) amendment(s) delineating any changes to the protocol,
(b) PI change,
(c) notification of serious or unexpected adverse effects and unanticipated problems involving risks to subjects and others within 24 hours, if applicable,
(d) publication clearance, travel orders, and funding requests,
(e) deviation reports,
(f) continuing review reports.

10. As the Principal Investigator, you have acknowledged that you will conduct this research IAW all local and Federal research regulatory requirements. If at any time you feel that you cannot perform this research IAW with those requirements, you must contact this office immediately.

11. You are reminded that a publication clearance is required for all written materials (i.e. manuscript, presentation, or abstract) being submitted for publication/presentation.

12. POC for this IRB action is Research Administration Service, Department of Clinical Investigation, Madigan Army Medical Center at (253) 968-1160.



VINCENT MYSLIWIEC, MD
LTC(P), MC
Chairman, Institutional Review Board

Appendix D

WESTERN REGIONAL MEDICAL COMMAND
MADIGAN ARMY MEDICAL CENTER
Tacoma, WA

Consent for Voluntary Participation in a Doctoral Dissertation Research Study Entitled: Doctoral Dissertation Study: African American Military Women and Female Spouses' Experiences of Care during the Prenatal Period

Principal Investigator: Mary-Paul Backman, CNM, Civilian,
Ob/Gyn Department, MAMC, 253-968-2497
Assistant Investigator: Thecly Scott, CNM, PhD Candidate
Duquesne University School of Nursing,
Ob/Gyn Department, NH Bremerton, 360-475-4995

Study site: Madigan Army Medical Center, Naval Hospital Bremerton

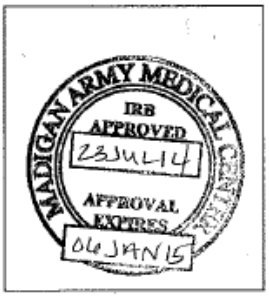
1. INTRODUCTION OF THE STUDY

You are being asked to be in this doctoral dissertation research study because I am interested in African American military women and female spouses' experiences of care during the prenatal period. Your participation is voluntary. Refusal to participate will not result in any punishment or loss of benefits to which you are otherwise permitted. Please read the information below and ask questions about anything you do not understand before deciding whether to take part in the study.

2. PURPOSE OF THE STUDY

The purpose of this dissertation research study is to learn about African American military women and female spouses' experiences of care during the prenatal period. I also seek to understand how world views, cultural and societal factors, and nursing practice influenced your care experiences during the prenatal period. Although you may not directly benefit from the study, you will have the knowledge that your participation in this study may provide information that will help improve nursing care during pregnancy, and that care may be based on African American culture, beliefs, values, and practices.

There have been no studies seeking to understand how African American women perceive care experienced during the prenatal period. This research and its potential findings may open discourse on prenatal care within the context of these women's lives. It will add to the growing body of nursing research related to prenatal care knowledge, but also recognize the importance of transcultural nursing and cultural care experiences during the prenatal period. Nursing care that is culturally congruent promotes optimal health and well-being, is useful to those receiving the care, and empowers clients to be active participants in their care planning.



The risks to you are rare as there are no known or anticipated risks greater than everyday activities as a result of you taking part in this study. In the unlikelihood that you would become distressed in any way during the interview or focus group, the researcher who is conducting the interview will stop the interview and talk with you. If needed, you will be referred to a health care professional at the local medical facility.

3. PROCEDURES TO BE FOLLOWED

If you agree to be in this study, you will be asked to participate in an interview and/or a focus group lasting approximately 1 - 2 hours. Focus groups allow women to share information in a group, rather than one-on-one with the researcher. Before the interview or focus group, you will be asked to complete an information form, but you will not put your name on the form. All information obtained in the study will be confidential. The PI would like your permission to audio-record the interviews and focus groups discussions to allow the information to be reviewed and prevent overlooking important information you provide. The Study investigators will transcribe the audiotapes and once the study has been completed the audiotapes will be destroyed.

4. AMOUNT OF TIME FOR YOU TO COMPLETE THE STUDY

You will be part of this study for one interview and/or one focus group. The interviews can be conducted at a time and date that is convenient to you. The focus group time and date will be arranged once there are four to six women who have agreed to participate in the focus group. You will be asked to visit the OB/GYN clinic one time if you desire to have your interview there and possibly one additional time if you desire to participate in the focus group. The interview and/or focus group may last approximately 1-2 hours.

5. NUMBER OF PEOPLE THAT WILL TAKE PART IN THIS STUDY

Approximately 48 women are expected to take part in this study at Madigan and Naval Hospital Bremerton.

6. POSSIBLE RISKS OR DISCOMFORTS FROM BEING IN THIS STUDY

The risks to you are rare as there are no known or anticipated risks as a result of you taking part in this study.

7. POSSIBLE BENEFITS FROM BEING IN THIS STUDY

There are no direct benefits to you from taking part in this study; however, the information we learn may help us learn how to improve nursing care during pregnancy that is based on African American culture, beliefs, values, and practices.

8. CONFIDENTIALITY/PRIVACY OF YOUR IDENTITY AND YOUR RESEARCH RECORDS

The Study Investigators will keep your research records. These records may be looked at by staff from Madigan Army Medical Center the Madigan Department of Clinical Investigation, Madigan Institutional Review Board (IRB), the Army Clinical Investigation Regulatory Office (CIRO), Army Human Research Protections Office (AHRPO), and other government agencies as part of their duties. These duties include making sure that you, the research participant, are protected.

Confidentiality of your records will be protected to the extent possible under existing regulations and laws but cannot be guaranteed. Complete confidentiality cannot be promised, particularly for military personnel, because information bearing on your health may be required to be reported to appropriate medical or command authorities. Your name will not appear in any published paper or presentation related to this study. Your name and any information about you will not appear on any survey or research instrument. No identity will be made in the data analysis. Your response(s) may appear as de-identified quotes in summaries of findings and in reports of the data presented in publications and/or presentations. These de-identified summaries may also be shared with members of a dissertation committee and staff from Madigan Army Medical Center. When the audio taped information is written out, any sections that identify subjects or anyone subjects talk about will be deleted. All written materials and consent forms will be stored in a locked file in the researcher's office at Madigan. All information relating to this study will be destroyed three years after completion of the study.

9. ADDITIONAL INFORMATION ABOUT THIS STUDY

The Sub-Investigator, Thecly Scott, is a Doctoral Candidate. This study is being conducted as partial fulfillment of the requirements for the degree of Doctor of Philosophy, Duquesne University School of Nursing. Dissertation Chair: Dr. Rick Zoucha, 412-396-6545

10. CONDITIONS UNDER WHICH YOUR PARTICIPATION IN THIS STUDY MAY BE STOPPED WITHOUT YOUR CONSENT

Your taking part in this dissertation study may be stopped without your consent if remaining in the study might be dangerous or harmful to you. Your taking part in this study may also be stopped without your consent if the military mission requires it, or if you lose your right to receive medical care at a military hospital. In the unlikelihood that you would become distressed in any way during the interview, the researcher who is conducting the interview or focus group will stop the interview or focus group and talk with you. If needed, you will be referred to a health care professional.

11. ELIGIBILITY AND PAYMENT FOR BEING IN THIS STUDY

You will not receive payment for being in this study.

12. COMPENSATION IF INJURED AND LIMITS TO MEDICAL CARE

There are no plans for you to receive any compensation (payment) should you be injured as a direct result of being in this study. This is not a waiver or release of your legal rights or any legal remedy available to you. You should discuss this issue thoroughly with the principal investigator before you enroll in this study.

Should you be injured as a result of your participation in this study, you will be given medical care for that injury at no cost to you. Medical care is limited to the care normally allowed for Department of Defense health care beneficiaries (patients eligible for TRICARE coverage and care at military hospitals and clinics). Necessary medical care does not include in-home care or nursing home care. If you need to be hospitalized, you may have to pay the normal fees for subsistence (hospital meals), as per standard regulations.

If at any time you believe you have suffered an injury or illness as a result of participating in this research project, you should contact the Department of Clinical Investigation, Madigan Army Medical Center at 253-968-0149.

13. COSTS THAT MAY RESULT FROM TAKING PART IN THIS STUDY

There is no charge to you for taking part in this study.

14. IF YOU DECIDE TO STOP TAKING PART IN THIS STUDY AND THE INSTRUCTIONS FOR STOPPING EARLY

You have the right to withdraw from this study at any time. If you decide to stop taking part in this study, you should tell the principal investigator as soon as possible; by leaving this study at any time, you in no way risk losing your right to medical care.

15. YOUR RIGHTS IF YOU TAKE PART IN THIS STUDY

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you and you will not lose any of your regular benefits. Leaving the study will not affect your medical care.

16. CONTACTS FOR QUESTIONS ABOUT THE STUDY

If you have questions about the study, or if you think you have a study-related injury, you should contact the (1) Principal Investigator, Mary-Paul Backman, Civilian, Certified Nurse-Midwife at [redacted] (*office*), (2) Assistant Investigator, Thecly Scott, PhD Candidate at [redacted] or (3) Rick Zoucha, Dissertation Chair at 412-396-6545. For questions about your rights as a research participant, contact the (1) Madigan Department of Clinical Investigation at 253-968-0149, (2) Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board at 412-396-6326, or (3) Madigan Staff Judge Advocate Office at 253-968-1525.

A copy of this signed consent form will be provided to you.

SIGNATURE OF RESEARCH PARTICIPANT

You have read the information in this consent form. You have been given a chance to ask questions and all of your questions have been answered to your satisfaction.

BY SIGNING THIS CONSENT FORM, I FREELY AGREE TO TAKE PART IN THE RESEARCH IT DESCRIBES.

_____ _____

Subject's Signature Date

_____

Subject's Printed Name

SIGNATURE OF INVESTIGATOR / PERSON CONDUCTING CONSENT

You have explained the research to the volunteer, and answered all of her questions. You believe that the volunteer subject understands the information described in this document and freely consents to participate.

_____ _____

Investigator's/Person Conducting Consent Signature Date (must be same as the subject's)

_____

Investigator's/Person Conducting Consent Printed Name

Appendix E

RESEARCH VOLUNTEERS NEEDED

African American Military Women
and Family Members
Who Have Had a Child or Children

To participate in a Doctoral Research Study about African American Military Women and Family's Members' Experiences of Care during the Prenatal Period

Eligibility Requirements:

-African American women 18 to 40 years old
-Currently on active duty in any branch of the military or the spouse of an active duty military member
-Had a child or children within the past 15 years
-Had prenatal care in a military or civilian facility in the United States or abroad
-Participate in an interview about your experience of care during the time when you were pregnant.

If you would like additional information about this study, please contact: Thecly (Theck-lee) Scott, Certified Nurse-Midwife, Doctoral Candidate, Duquesne University, School of Nursing, [redacted]

Appendix F

RESEARCH VOLUNTEERS NEEDED

African American Military Women and Family Members Who Have Had a Child or Children

to participate in a
Doctoral Research Study about
African American Military Women and
Family Members' Experiences of Care
during the Prenatal Period

Eligibility Requirements

-African American women 18 to 40 years old
-Currently on active duty in any branch of the military or the spouse of an active duty military member
-Had a child or children within the past 15 years
-Had prenatal care in a military or civilian facility in the United States or abroad
-Participate in an interview about your experience of care during the time when you were pregnant.

If you would like to participate in this study, please contact: Thecly (Theck-lee) Scott, Certified Nurse-Midwife, Doctoral Candidate, Duquesne University, School of Nursing, [redacted]

RESEARCH VOLUNTEERS NEEDED

African American Military Women and Family Members Who Have Had a Child or Children

to participate in a
Doctoral Research Study about
African American Military Women and
Family Members' Experiences of Care
during the Prenatal Period

Eligibility Requirements

-African American women 18 to 40 years old
-Currently on active duty in any branch of the military or the spouse of an active duty military member
-Had a child or children within the past 15 years
-Had prenatal care in a military or civilian facility in the United States or abroad
-Participate in an interview about your experience of care during the time when you were pregnant.

If you would like to participate in this study, please contact: Thecly (Theck-lee) Scott, Certified Nurse-Midwife, Doctoral Candidate, Duquesne University, School of Nursing, [redacted]

Appendix G

DUQUESNE UNIVERSITY

Volunteer

CONFIDENTIALITY STATEMENT

I understand that as a volunteer for a research study being conducted by Thecly Scott, PhD Candidate at the Duquesne University School of Nursing, investigating African American military women and female spouses' perceptions of care experienced during the prenatal period, I have access to confidential information. I understand that I will not be participating in the research study and will only be a volunteer to assist where needed. I agree to keep all events observed in this study confidential, and I will not discuss or reveal the contents of the data collection to anyone outside of the research team.

Name:_____

Signature:_____

Date:_____

Witness Signature: _____

Appendix H

Verbal Explanation of Consent Form

My name is Thecly Scott and I am a Doctoral Candidate in the School of Nursing at Duquesne University, Pittsburgh Pennsylvania. This dissertation research study is being conducted as a requirement for the Doctor of Philosophy degree. You are being asked to be in this research study because I am interested in military African American women and female spouses' experiences of care during the prenatal period. Your participation is voluntary. Refusal to participate will not result in any punishment or loss of benefits to which you are otherwise permitted.

The purpose of this research study is to learn about military African American women and female spouses' experiences of care during the prenatal period. I also seek to understand how worldviews, cultural and societal factors, and nursing practice influenced your care experiences during the prenatal period. Although you may not directly benefit from the study, you will have the knowledge that your participation in this study may provide information that will help improve nursing care during pregnancy that is based on African American culture, beliefs, values, and practices.

If you decide to participate in this study, you will be asked to complete a demographic form and participate in an interview (focus group) lasting approximately 1 - 2 hours. All information obtained in the study will be confidential and you will not be asked to identify yourself on the demographic form or during the interview (focus group).

I would like your permission to audio-record the interview (focus groups) discussions to allow me to review the information, and prevent me from overlooking important information given by you. The recorded information will be written out by me. The recorded information will be destroyed at the end of the study.

There are no known or anticipated risks greater than everyday activities as a result of you taking part in this study. In the unlikelihood that you would become distressed in any way during the interview (focus group), the researcher who is conducting the interview will stop the interview and talk with you. If needed, you will be referred to a health care professional at the local medical facility.

Your participation in this study is entirely voluntary and you may withdraw your consent at any time without consequences of any kind. You may refuse to answer questions that you don't want to answer and still remain in the study.

Appendix I

African American Military Women and Female Spouses' Experiences of Care During the Prenatal Period	
ETHNODEMOGRAPHICS	
Informant #:	Age:
Branch of service:	Active duty or dependent:
Marital status:	Birthplace:
Number of children:	Other family in area: yes no Who?
Did you get prenatal care from a doctor, midwife, elders, family, other care provider (please identify) Where in the U.S. or abroad: Large or small facility?	Approximately how many prenatal visits did you have? (please give an approximate number) Did you participate in group prenatal care? Was your spouse/partner deployed during the time you were receiving prenatal care?

Appendix J

African American Military Women and Female spouses' Experiences of Care During the Prenatal Period

Semi-structured interview guide

Introduction

The purpose of this interview is to learn from you about factors that influenced your care during the prenatal period (the time when you were pregnant).

Kinship and social factors

I would like to hear about your care during the prenatal period, the time when you were pregnant.

1. Tell me how your family and friends supported you during your pregnancy.
2. If you were not born in this area, what brought you to this area?
3. If your husband/partner deployed during the prenatal period, how did this impact your prenatal care?
4. How did your partner help you during the prenatal period?
5. If your family was away, how did they help you during your pregnancy?
6. If you were at home with family, how do you think your care would have been different?

Prenatal Care

I would like to hear your views on prenatal care and your experience. Tell me about the care you experienced in the military health system during your pregnancy.

1. What does prenatal care mean to you?
2. Please tell me what the terms "health" and "healthy pregnancy" means to you.
3. When did you first come for prenatal care? How many weeks or which trimester?
4. What made you come for prenatal care?
5. Tell me some of the things you did to care for yourself during the prenatal period.
6. Tell me about barriers to receiving prenatal care you may have experiences.
7. Tell me about classes/resources that were available during your prenatal period.

Cultural/Religious/Spiritual/Worldviews

I would like to know about your cultural values and beliefs regarding life and health.

1. Please describe how your cultural beliefs, practices, and values influenced the way you cared for yourself during your pregnancy.
2. Tell me about traditional or cultural food you ate to stay well during the prenatal period.
3. Tell me some of the things you did to maintain good health during the prenatal period.
4. Tell me about practices or activities you did (avoided) to stay well.
5. Tell me about superstitions or "wives tales" you held about prenatal care or pregnancy.

Technological factors

1. Describe the ways you obtained prenatal information during your pregnancy.
2. Tell me about technologies you use and how you used them.

Economics

1. How did the cost of health care influence your prenatal care decisions?
2. What were your concerns about money related to your prenatal care experience?
3. In what ways did money support or hinder your care experience during the prenatal period?

Professional and generic (traditional) care beliefs and practices

1. How did health care professionals impact or support your prenatal care decisions?
2. What were your expectations regarding nursing care?

3. Did nursing practices influence (support or hinder) whether you received prenatal care?
4. Tell me what you believe would be most helpful to learn from nurses about prenatal care.

Military and prenatal period

I would like to learn about the military and your experience of care

1. How did the military impact or support your care experience?
2. Active duty/Spouse: Tell me how the military supported or hindered your spouse or partner during the prenatal period.
3. Is there anything else you would like to tell me about the military and the care you received during the prenatal period?

Closure

We are almost done with the interview (focus group),

1. Is there anything else you would like to tell me about your prenatal care experiences?
2. Is there anything else you would like to tell me about how you or someone else cared for you during the prenatal period?
3. Is there anything you want to share with me before we close?

Appendix K

Clinical Investigation Department
Naval Medical Center, San Diego
34800 Bob Wilson Drive, Suite 5
San Diego, CA 92134-1005
Tel: 619-532-8136; FAX: 619-532-8137
Email: michael.coronado@med.navy.mil

May 29, 2014

From: Head, Clinical Investigation Department (CID)

To: **Thecly Scott, MSN**

Subj: **FINAL APPROVAL OF CLINICAL INVESTIGATION PROGRAM (CIP)**
STUDY CIP #NMCSD.SSA.2014.0087, "[402303-1] Doctoral Dissertation Study: African American Military Women and Female Spouses' Experiences of Care during the Prenatal Period"

Ref: (a) NAVMEDCEN SDIEGOINST 6500.9A

1. The Naval Medical Center San Diego Institutional Review Board (IRB) has deferred the IRB review of this application that involves human research subjects, as reported in the July 10, 2013 IRB meeting minutes. The Chairman has reviewed all local site-specific and core protocol documents attached to the original submission.

2. **CLINICAL INVESTIGATION PROGRAM NUMBER (CIP#):** NMCSD.SSA.2014.0087
This number is the clinical investigation program number and is required to be included with all correspondence, consent forms, and research data files.

4. **ADVERSE EVENT (AE) REPORTING:** All problems that could possibly effect subject safety must be reported to the IRB within five days; serious AEs must be reported within 24 hours. All deaths, whether or not they are directly related to study procedures, must be reported.

5. **AMENDMENTS:** Prior IRB approval is required before implementing *any* changes to the protocol, including investigator additions or deletions, edits to consent documents or any other modifications to the documentation contained in the original submission package. These amendments should be reported to the NMCSD IRB following submission to and approval by the MAMC IRB.

6. **EXPIRATION DATE:** Your protocol will expire on January 6, 2015. If the project is to continue, it must be renewed ***prior to the expiration date***. The IRB wishes to remind you that according to the Department of Health and Human Services (DHHS) and NMCSD policy, the renewal of research projects is the ***Investigator's*** responsibility and a renewal application is required ***at least*** annually for all projects involving human subjects.

7. **COMMENT: The Research Administration Office will send you a *Continuing Review Report (CRR) approximately 60 days prior to the expiration of the study.*** The IRB wishes to remind you that, according to the Department of Health and Human Services (DHHS) and NMCSD policy, the renewal of exempt research projects is the ***Investigator's*** responsibility and a renewal application is required ***at least*** annually for all projects involving human subjects.

8. **ARTICLES/ABSTRACTS/POSTERS:** : If you wish to submit an item for publication or presentation, it must be submitted to the CID Medical Editing Lead Editor, Ms. Elisea Avalos, who can be reached

at (619) 532-8134. She will assist in their preparation, ensure proper acknowledgment of BUMED as sponsor, obtain command approval, and submit them to publications.

9. The Principal Investigator is responsible for obtaining final authorization to begin implementation and recruitment from supporting sites. The PI is responsible for contacting the respective Command Research Coordinator or Command Research Facilitator.

10. **QUESTIONS:** Please contact the IRB Research Administration Division (RAD) if you have any questions: Michael Coronado at 619-532-8136

J.D. Malone, MD
Head, Clinical Investigation Department

Appendix L

Leininger's Phases of Ethnonursing Qualitative Data Analysis*

Fourth Phase

Major Themes, Research Findings, Theoretical Formulations, and Recommendations

This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configuration, analysis, interpreting findings, and creative formulations from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and sometimes theoretical formulations.

Third Phase

Pattern and Contextual Analysis

Data are scrutinized to discover saturated ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are examined to show patterning with respect to meanings in-context and along with further credibility and confirmation of findings.

Second Phase

Identification and Categorization of Descriptors and Components

Data are coded and classified as related to the domain of inquiry and sometimes the questions. Emic and etic descriptors are studied within context for similarities and differences. Recurrent components are studied for their meanings.

First Phase

Collecting, Describing, and Documenting Raw Data (with Field Journal or Computer)

Researcher collects, describes, records, and begins to collect data related to the purposes, domain of inquiry, or questions under study. This phase includes: recording interview data from key and general informants, making observations and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomena under study, from an emic focus, but attentive to etic data. Data from the condensed and full field journal is processed directly into the computer, coded by hand.

Leininger and McFarland (2002, p. 95)